SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Filing at a Glance

Company: National Guardian Life Insurance Company

Product Name: DI and POI	SERFF Tr Num: HARP-125623027	State: ArkansasLH
TOI: H11G Group Health - Disability Income	SERFF Status: Closed	State Tr Num: 39357
Sub-TOI: H11G.005 Combined Short Term and Long Term	Co Tr Num: NGL001	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Marsha Clark	Disposition Date: 06/23/2008
	Date Submitted: 06/20/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association, Trust, Other
Filing Status Changed: 06/23/2008	
State Status Changed: 06/23/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Purpose

In our capacity as the Reinsurer and designated filing agent, we are submitting the enclosed forms on behalf of National Guardian Life Insurance Company (“National Guardian”) for your review and approval.

This is a new filing and the forms present a program of group disability income insurance.

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Submitted Material

The Booklet Certificates are being filed in sections with separate form numbers. When the certificate is assembled, the basic form number will appear on the face page of the certificate and the pages will be run in continuous text, without the extended form numbers. I have included a complete form listing.

The Policy of Incorporation is a generic product and is intended for use with our Disability certificates as well as our Life Insurance and Accidental Death and Dismemberment certificates, which will be filed separately. We are asking that you approve this policy for use with those certificates also and we will reference your approval in the filing approval folder of those forms. When the policy is assembled, it will retain the form number on the bottom of each page.

In addition, the master application, enrollment form and personal health information forms are generic and intended for use with our Disability product, as well as with our Life Insurance and Accidental Death and Dismemberment product. We are asking that you approve these forms for use with those certificates also and we will reference your approval in the filing approval folder of those forms.

Flesch Test

The certificates have been tested for readability and achieve the following Flesch readability scores: LTD Certificate scores 42.6 and the LTD Certificate scores 43.5. The policy has been tested as well and it achieves a Flesch readability score of 40.5.

Variability of Forms

The variable material is set off by brackets to be variable so that it may be added to, deleted from or changed. Each of the certificates and the Policy of Incorporation are accompanied by Statements of Variable Language to explain the intended range of variability.

Company and Contact

Filing Contact Information

(This filing was made by a third party - TheHartford03)

Marsha Clark, marsha.j.clark@hartfordlife.com
7 Waterside Crossing (860) 843-3804 [Phone]

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
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TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Windsor, CT 06095 (860) 392-5856[FAX]

Filing Company Information

National Guardian Life Insurance Company	CoCode: 66583	State of Domicile: Wisconsin
2 East Gilman Street	Group Code: 1211	Company Type: Life & Health
Madison, WI 53701	Group Name:	State ID Number:
(608) 443-5325 ext. [Phone]	FEIN Number: 39-0493780	

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Arkansas fee is $50 per submission.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life Insurance Company	$50.00	06/20/2008	21010923

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
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Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/23/2008	06/23/2008

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
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Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/23/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	POI Forms List	Approved-Closed	Yes
Supporting Document	Certificate Forms List	Approved-Closed	Yes
Supporting Document	POI Statement of Variable Language	Approved-Closed	Yes
Supporting Document	LTD Statement of Variable Language	Approved-Closed	Yes
Supporting Document	STD Statement of Variable Language	Approved-Closed	Yes
Supporting Document	Guaranty Assoc. Notice	Approved-Closed	Yes
Form	Face Page	Approved-Closed	Yes
Form	Schedule of Insurance	Approved-Closed	Yes
Form	Premium Provisions	Approved-Closed	Yes
Form	Premium Schedule	Approved-Closed	Yes
Form	Participating Entities	Approved-Closed	Yes
Form	Policy Provisions	Approved-Closed	Yes
Form	Incorporation Provision	Approved-Closed	Yes
Form	Policy Modifications	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Personal Health Statement	Approved-Closed	Yes
Form	LTD Face Page	Approved-Closed	Yes
Form	LTD Schedule of Insurance	Approved-Closed	Yes
Form	LTD Definitions	Approved-Closed	Yes
Form	LTD Eligibility & Enrollment	Approved-Closed	Yes
Form	LTD Period of Coverage	Approved-Closed	Yes
Form	LTD Benefits	Approved-Closed	Yes
Form	LTD Termination of Payment	Approved-Closed	Yes
Form	LTD Family Care Credit and COLA	Approved-Closed	Yes
Form	LTD Survivor Income Benefit	Approved-Closed	Yes
Form	LTD Extended Earnings Protection and Workplace Modification	Approved-Closed	Yes
Form	LTD Pension Contribution and Infectious	Approved-Closed	Yes

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
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Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Disease

Form	LTD Activities of Daily Living	Approved-Closed	Yes
Form	LTD Accidental Dismemberment and Loss of Sight Benefit	Approved-Closed	Yes
Form	LTD Business Protection Benefit	Approved-Closed	Yes
Form	LTD Exclusions & Limitations	Approved-Closed	Yes
Form	LTD General Provisions	Approved-Closed	Yes
Form	LTD Rider Form	Approved-Closed	Yes
Form	STD Face Page	Approved-Closed	Yes
Form	STD Schedule of Insurance	Approved-Closed	Yes
Form	STD Definitions	Approved-Closed	Yes
Form	STD Eligibility & Enrollment	Approved-Closed	Yes
Form	STD Period of Coverage	Approved-Closed	Yes
Form	STD Benefits	Approved-Closed	Yes
Form	STD REhabilitative Employment Benefit	Approved-Closed	Yes
Form	STD COLA Benefit	Approved-Closed	Yes
Form	STD Cafeteria Plan Election Restriction	Approved-Closed	Yes
Form	STD Exclusions & Limitations	Approved-Closed	Yes
Form	STD General Provisions	Approved-Closed	Yes
Form	STD Rider Form	Approved-Closed	Yes

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
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Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: NHCRTLTD 4/08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	NHGRPOL	Policy/Contract/Fraternal Certificate	Face Page	Initial		40	NHGRPOL_Face Page.pdf
Approved-Closed	NHGRPOL-SCH (AR)	Policy/Contract/Fraternal Certificate	Schedule of Insurance	Initial		40	NHGRPOL-SCH_Schedule.pdf
Approved-Closed	NHGRPOL-PX	Policy/Contract/Fraternal Certificate	Premium Provisions	Initial		40	NHGRPOL-PX_Premium Provisions.pdf
Approved-Closed	NHGRPOL-PXSch	Policy/Contract/Fraternal Certificate	Premium Schedule	Initial		40	NHGRPOL-PXSch_Premium Schedule.pdf
Approved-Closed	NHGRPOL-Par	Policy/Contract/Fraternal Certificate	Participating Entities	Initial		40	NHGRPOL-Par_Participating Entities.pdf
Approved-Closed	NHGRPOL-Prov	Policy/Contract/Fraternal Certificate	Policy Provisions	Initial		40	NHGRPOL-Prov_Policy Provisions.pdf
Approved-Closed	NHGRPOL-Inc	Policy/Contract/Fraternal Certificate	Incorporation Provision	Initial		40	NHGRPOL-Inc_Incorporation Provision.pdf
Approved-Closed	NHGRPOL-RID	Policy/Contract/Fraternal Certificate	Policy Modifications	Initial		40	NHGRPOL-RID_Policy Modifications.pdf

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*			
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*			
Company Tracking Number:	*NGL001*					
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*			
Product Name:	*DI and POI*					
Project Name/Number:	*/*					

Approved-Closed	NVI/NDN Grp App 04/08	Application/ Enrollment Form	Master Application	Initial		Combined Master Application rev608.pdf
Approved-Closed	NDN/VI/OTH Enroll 04/08	Application/ Enrollment Form	Enrollment Form	Initial		2006-NDN-VI-OTH Enroll - Enrollment Form rev308_2_.pdf
Approved-Closed	PHI 0308	Application/ Enrollment Form	Personal Health Statement	Initial		PHI 3-08.pdf
Approved-Closed	NHCRTLTD	Certificate	LTD Face Page	Initial	43	NHCRTLTD_Face Page.pdf
Approved-Closed	NHCRTLTD-SCH	Certificate	LTD Schedule of Insurance	Initial	43	NHCRTLTD-SCH _AR_2008-06-18 .pdf
Approved-Closed	NHCRTLTD-DEF	Certificate	LTD Definitions	Initial	43	NHCRTLTD-DEF_Definitions.pdf
Approved-Closed	NHCRTLTD-E&E	Certificate	LTD Eligibility & Enrollment	Initial	43	NHCRTLTD-E&E_Eligibility.pdf
Approved-Closed	NHCRTLTD-PoC	Certificate	LTD Period of Coverage	Initial	43	NHCRTLTD-PoC_Period of Coverage.pdf
Approved-Closed	NHCRTLTD-BEN	Certificate	LTD Benefits	Initial	43	NHCRTLTD-BEN_Benefits.pdf
Approved-Closed	NHCRTLTD-BEN-Term	Certificate	LTD Termination of Payment	Initial	43	NHCRTLTD-BEN-Term_Termination.pdf
Approved-Closed	NHCRTLTD-BEN-	Certificate	LTD Family Care Credit and COLA	Initial	43	NHCRTLTD-BEN-

	FC/Cola						FCCola_Family Care and COLA.pdf
Approved-Closed	NHCRTLTD-BEN-SurvInc	Certificate	LTD Survivor Income Benefit	Initial		43	NHCRTLTD-SurvInc_Survivor Income.pdf
Approved-Closed	NHCRTLTD-BEN-ExtErn/Wrk	Certificate	LTD Extended Earnings Protection and Workplace Modification	Initial		43	NHCRTLTD-BEN-ExtErnWrk_Extended Earnings and Workplace Modification.pdf
Approved-Closed	NHCRTLTD-BEN-PC/ICD	Certificate	LTD Pension Contribution and Infectious Disease	Initial		43	NHCRTLTD-BEN-PCICD_Pension Contrib and Infectious Disease.pdf
Approved-Closed	NHCRTLTD-BEN-ADL	Certificate	LTD Activities of Daily Living	Initial		43	NHCRTLTD-BEN-ADL_Activites of Daily Living.pdf
Approved-Closed	NHCRTLTD-BEN-AD	Certificate	LTD Accidental Dismemberment and Loss of Sight Benefit	Initial		43	NHCRTLTD-BEN-AD_Accidental Dismemberment.pdf
Approved-Closed	NHCRTLTD-BEN-BsProt	Certificate	LTD Business Protection Benefit	Initial		43	NHCRTLTD-BEN-BsProt_Business Protection.pdf
Approved-	NHCRTLT	Certificate	LTD Exclusions &	Initial		43	NHCRTLTD-

Closed	D-EXCL		Limitations			EXCL_Exclusions.pdf
Approved-Closed	NHCRTLTD-Prov	Certificate	LTD General Provisions	Initial	43	NHCRTLTD-Prov_General Provisions.pdf
Approved-Closed	NHCRTLTD-RID	Certificate	LTD Rider Form	Initial	43	NHCRTLTD-RID_Rider Form.pdf
Approved-Closed	NHCRTSTD	Certificate	STD Face Page	Initial	44	NHCRTSTD_Face Page.pdf
Approved-Closed	NHCRTSTD-SCH (AR)	Certificate	STD Schedule of Insurance	Initial	44	NHCRTSTD-SCH _AR_2008-06-18.pdf
Approved-Closed	NHCRTSTD-DEF	Certificate	STD Definitions	Initial	44	NHCRTSTD-DEF_Definitions.pdf
Approved-Closed	NHCRTSTD-E&E	Certificate	STD Eligibility & Enrollment	Initial	44	NHCRTSTD-E&E_Eligibility.pdf
Approved-Closed	NHCRTSTD-PoC	Certificate	STD Period of Coverage	Initial	44	NHCRTSTD-PoC_Period of Coverage.pdf
Approved-Closed	NHCRTSTD-BEN	Certificate	STD Benefits	Initial	44	NHCRTSTD-BEN_Benefits.pdf
Approved-Closed	NHCRTSTD-BEN-Rehab	Certificate	STD REhabilitative Employment Benefit	Initial	44	NHCRTSTD-BEN-Rehab_Rehabilitative Employment.pdf
Approved-Closed	NHCRTSTD-BEN-Cola	Certificate	STD COLA Benefit	Initial	44	NHCRTSTD-BEN-Cola_Cost-of-Living

							Adjustment.pdf
Approved-Closed	NHCRTSTD-BEN-Caf	Certificate	STD Cafeteria Plan Election Restriction	Initial		44	NHCRTSTD-BEN-Caf_Cafeteria Plan Restriction.pdf
Approved-Closed	NHCRTSTD-EXCL	Certificate	STD Exclusions & Limitations	Initial		44	NHCRTSTD-EXCL_Exclusions.pdf
Approved-Closed	NHCRTSTD-Prov	Certificate	STD General Provisions	Initial		44	NHCRTSTD-Prov_General Provisions.pdf
Approved-Closed	NHCRTSTD-RID	Certificate	STD Rider Form	Initial		44	NHCRTSTD-RID_Rider Form.pdf

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

Name of Policyholder: [ABC POLICYHOLDER**]**

Policy Number:	**Effective Date:**	**Place of Delivery:**
[XXXXXX**]**	**[**January 1, 2004**]**	**[**ANY STATE**]**

Anniversary Dates:	**Premium Due Dates:**
[January 1 of each year beginning in 2005**]**	[Monthly, on the first day of each policy month]

Administrator: [Insert Administrator Name
Insert Administrator Address]

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
will pay benefits according to the terms and conditions of The Policy.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President]

[TEN DAY RIGHT TO EXAMINE POLICY

The Company urges you to examine this policy closely. If you are not satisfied with it, you may send it back to The Company for any reason within 10 days after the date you receive it. If so returned, your insurance will be canceled, and any premium paid will be refunded in full.]

:

Countersigned by.....……..
[Licensed Resident Agent or] Registrar

Table of Contents

Schedule of Insurance

The Schedule(s) of Insurance for The Policy benefits listed below are shown in the Certificate(s), as incorporated into The Policy.

1) [Basic Life Insurance
2) Supplemental Life Insurance
3) Accidental Death, Dismemberment and Loss of Sight Benefit
4) Supplemental Accidental Death, Dismemberment and Loss of Sight Benefit
5) Dependent Life Insurance
6) Spouse Accidental Death, Dismemberment and Loss of Sight Benefit
7) Short Term Disability Insurance
8) Long Term Disability Insurance
9) Supplemental Spouse Accidental Death Dismemberment and Loss of Sight Benefit]

The Schedule(s) of Insurance will control the:

1) [benefit amounts and maximum limits;
2) eligibility and effective date requirements; and
3) other schedule amounts and limits;

which apply to the employees of the Policyholder.]

Premium Provisions

Initial Monthly Premium Rates

The initial monthly premium rates to be charged [for employee Coverage and/or child/spouse coverage, if applicable, are shown on the following page(s).]

The first premium is due and payable on the effective date of The Policy. Subject to The Policy's grace period provision, all premiums after the first must be paid when or before they are due.

[Premiums are based on the Employee's:

1) age on his or her effective date and thereafter on the first day of the month following the month in which his or her birthday occurs;]
2) [sex and occupational class.]

[For Long Term Disability Benefits, the amount of an employee's Earnings which is disregarded in determining his Monthly Benefit because of the Maximum Monthly Benefit limitation will also be disregarded in determining the amount of the total insured payroll.]

The Initial Monthly Premium Rates may be converted as follows:

To Convert Rates to:	**Use a Conversion Factor of:**
-- annual rates	11.8227
-- semi-annual rates	5.9557
-- quarterly rates	2.9852

Grace Period

The Company will allow the Policyholder a [31] day grace period for the payment of all premiums after the first. During this [31] day period, The Policy will stay in force. If the owed premium is not paid by the [31st] day, The Policy will automatically terminate. If the Policyholder gives The Company written advance notice of an earlier cancellation date, The Policy will terminate on the earlier date. Premium is due for each day The Policy is in force.

[Monthly Premium Rate Guarantee

Initial Monthly Premium rates are guaranteed as follows:

Benefit	**Rate Guarantee Period**
[Basic Life Insurance	6 months
Basic Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Life Insurance	6 months
Supplemental Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Dependent Life Insurance	6 months
Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Long Short Term Disability Benefits Term Disability Benefits	6 months]

[Subject to the Rate Guarantee period shown above, The Company has the right to change premium rates on any premium due date if:

1) written notice is delivered to the Policyholder's last address on record; and
2) the change is effective at least [31] days after the date of notice.]

[The Rate Guarantee supersedes only those provisions appearing elsewhere in this policy which give The Company the right to change the premium rates, and then, only for the period of time for which the rates are guaranteed. However, The Company may change the premium rates during the Rate Guarantee period if there is a [10%] change in The Policy, or if there is an increase or decrease in the number of insured employees, or if the Policyholder adds or deletes a subsidiary or affiliated business entity. The Company may also change the premium rates during the Guarantee Period if there has been a material misstatement in the reported experience during the pre-sale process. The Rate Guarantee in no way affects, amends or supersedes any other provision in The Policy.]

Premium Provisions

Calculation
Premiums may be calculated by multiplying the rate times the applicable number of units of coverage.

If any insurance is added, increased or becomes effective after The Policy is in force, the premium charges will begin on:
1) the day the coverage is effective, if it is also the first day of a policy month; or
2) the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month. [With respect to Dependent Life Insurance only, the premium rate per Dependent Unit or per $1,000 of insurance, whichever is applicable, will be based on actuarial assumptions, due to the difficulty in obtaining the ages of all Dependents who are covered under this benefit. The actuarial assumptions will produce, in the opinion of The Company, the same total amount of premium as would be obtained by the use of the actual ages of the Dependents covered.]

Premiums may be calculated by any other method which both The Company and the Policyholder agree to in writing.

Premium Payments
Premium payments are due and payable in full to a place designated by The Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of The Company. Payment of premiums for a period before it is due will not guarantee the insurance for that period.

[Experience Rating
If The Policy is experience rated, any credit amount due the Policyholder will be allowed on The Policy Anniversary Date and, at the Policyholder's request, will be:
1) paid to the Policyholder in cash;
2) used to reduce the Policyholder premiums; or
3) used to provide additional insurance for Covered Persons.

Any credit amount shall be determined by the rating plan or plans used by The Company.]

[Combined Experience
If the experience of The Policy is combined with other policies, it shall be combined only with the experience of the following Policies: XXXXX; XXXXX and XXXXX]

PREMIUM SCHEDULE

[Long Term Disability: PREMIUMS
Short Term Disability: PREMIUMS
Life Insurance: PREMIUMS
Accidental Death and Dismemberment: PREMIUMS]

Participating [Entities]

The Policyholder means [ABC Policyholder.]

Participating [Entity] means any [Entity] that has [become a member of ABC Policyholder.]

The Company or The Policyholder, by written request, may add to or delete from the list of Participating [Entities] in The Policy [at any time.] [The Company will keep a list of Participating [Employers] accepted by The Company and the effective dates of coverage for each.]

Any change, subject to The Company's written approval, will become effective [on a date which is mutually agreeable to the Policyholder and The Company.] The Policyholder may act for or on behalf of all Participating [Entities] in all matters of The Policy. The following will be binding on all Participating [Entities]:

1) all agreements between The Company and the Policyholder;
2) all notices from The Company to the Policyholder; and
3) all notices from the Policyholder to The Company.

Each reference in the Policy to a relationship between the Policyholder and its Eligible Persons includes the same relationship between each Participating [Entity] and its [Eligible Persons], except where the Policy describes specific differences.

Individual Effective Date: A person associated with a Participating [Entity] will not:

1) become an Eligible Person before the [Entity] qualifies; or
2) continue as an Eligible Person after the [Entity] ceases to qualify;

as a Participating [Entity].

Premiums: A Participating [Entity]'s premiums will be calculated based on:[

1) the coverage requested; and
2) the data given to The Company by the Participating [Entity].]

[Data Given by Participating [Entity]: The Participating [Entity], with our approval, may keep the important insurance records on all persons covered under The Policy. The Participating [Entity] or its designee must give The Company information, when and in the manner The Company asks, to administer the insurance provided by the Policy.

[The Participating [Entity] will, upon our request, give us:

1) the names of all persons initially eligible for coverage;
2) the names of all additional persons who become eligible for coverage;
3) the names of all persons whose amount of insurance is to be changed;
4) the names of all persons whose eligibility or insurance is terminated; and
5) any data necessary to administer the insurance provided by the Policy.]

The Participating [Entity]'s failure to:

1) give The Company the name of any person covered under The Policy will not invalidate such person's insurance;
2) [report a person's termination of insurance will not continue the coverage beyond the date of termination.]

The Policyholder's and/or Participating [Entity]'s insurance records will be open for our inspection at any reasonable time.

Upon termination of coverage, any unearned premium will be calculated on a pro-rata basis. The Company will promptly return any unearned premium paid.]

Participating [Entity] Termination Date: A Participating [Entity] will cease to be covered on the first to occur of:

1) [the date the Participating [Entity] ceases to be a member of the Policyholder;
2) the date requested by the Participating [Entity] but not prior to The Company's receipt of the request;
3) the termination date of the Policy;
4) the date the Participating [Entity's] premium is due, but not paid; or
5) the date on which the Policyholder requests that the [Entity] be removed from The Policy. Such date must be stated in a written notice to The Company, and must be after the date of the notice.

Participating [Entities]

[**Name of Participating [Entity]**	**Effective Date**	**Account Number**	**Termination Date**
ABC [Entity]	January 1, 2004	000-00-0000	]

]

Policy Provisions

Entire Contract:
The contract between the parties consists of:

1) the Policy;
2) any certificates incorporated and made a part of the Policy;
3) any riders issued in connection with such certificates;
4) the Policyholder's application, if any, a copy of which is attached to and made a part of The Policy when issued; and
5) any Written Medical Insurability Application submitted by the Eligible Person/Employee and accepted by The Company in connection with the Policy.

All statements made by the Policyholder, Participating [Entity] or persons insured under The Policy will be deemed representations and not warranties. No statement made to effect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary.

Incontestability:
Except for non-payment of premium, the insurance provided by The Policy cannot be contested after such insurance has been in effect for a period of [2 years.]

Changes: The Company reserves the right to make changes in the Policy, [after The Policy has been in force for 12 months.] The Company will give the Policyholder [31 days] advance written notice of any change. No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, approved by one of our officers and made a part of the Policy.

[**30 Day Right to Examine Certificate:** The Insured Person has a [30 day] right to examine his or her Certificate. If the [Insured Person] is not satisfied, he or she may return it to The Company within [30 days] of his or her effective date. In that event, The Company will consider it void from the certificate effective date and any premium paid will be refunded. Any claims paid under the Policy during the initial [30 day] period will be deducted from the refund.]

Clerical Error: Clerical error (whether by the Policyholder, the Plan Administrator, or us) in keeping the records having to do with the Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. A clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by the Policy. When a clerical error is found, premiums and benefits will be adjusted based on the true facts and the Policy.

Conformity with Law: If any provision of the Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law, including but not limited to the Federal Social Security Act, affects The Company's liability under The Policy, The Company may change The Policy, the premiums or both. Such change:

1) will be effective as of the date of the change to the state or federal law; and
2) will not be made until The Company gives the Policyholder [31 days] notice**.**

[Termination of Policy
The Company may terminate The Policy for the following reasons by giving the Policyholder [31] days written notice:

1) The Policyholder fails to furnish any information which The Company may reasonably require;
2) The Policyholder fails to perform any of his other obligations pertaining to this policy;
3) [Less than 100% of the persons eligible for coverage on a Non-contributory Basis are insured; or]
4) [Less than 75% of the persons eligible for coverage on a Contributory Basis are insured.]
5) [Fewer than 10 persons are insured.]

In addition, The Company may terminate this policy on any premium due date after The Policy has been in force for [12 months] by providing [31 days] written notice.

The Company reserves the right to terminate Dependent Life Insurance Benefits on any premium due date on which:

1) [there are fewer than 10 persons insured for Dependent Coverage; or]
2) [less than 75% of the persons eligible for Dependent Coverage on a Contributory Basis are insured.]

The Company shall give the Policyholder [31 days] notice of its intent to terminate the Dependent Life Insurance Benefit.]

Policy Provisions

[**Cancellation:** The Policy may be cancelled [at any time] by written notice mailed or delivered by The Company to the Policyholder, or by the Policyholder to us. If The Company cancels, The Company will mail or deliver the notice to the Policyholder at its last address shown in our records. If The Company cancels, it becomes effective [on the later of:

1) the date stated in the notice; or
2) the 31st day after The Company mails or delivers the notice.]

If the Policyholder cancels, it becomes effective [on the later of:

1) the date The Company receives the notice; or
2) the date stated in the notice.]

In either event:

1) The Company will promptly return to the Policyholder any unearned premium; or
2) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis. Cancellation will be without prejudice to any claim which commenced prior to the effective date of the cancellation.]

Certificates: The Company will give individual certificates to:

1) the Policyholder; or
2) any other person according to a mutual agreement among the other person, the Policyholder, and us;

for delivery to persons covered under The Policy and which will explain the important features of The Policy.

Data To Be Furnished

The Policyholder, or any other person designated by the Policyholder, will give The Company all information The Company needs regarding matters pertaining to the insurance. At any reasonable time while The Policy is in force and for [12 months] after that, The Company may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this policy.

The Policyholder will, upon our request, give us:

1) [the names of all persons initially eligible for coverage;
2) the names of all additional persons who become eligible for coverage;
3) the names of all persons whose amount of insurance is to be changed;
4) the names of all persons whose eligibility or insurance is terminated; and
5) any data necessary to administer the insurance provided by the Policy.]

If the Policyholder gives The Company any incorrect information, the relevant facts will be determined to establish if insurance is in effect and in what amount.

No person will be deprived of insurance to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the Policyholder. Any required adjustment may be made in premiums or benefits.

Right to Audit: The Company reserves the right to audit, [once every 2 years,] the Policyholder's billing records and premium accounting practices. If The Company discovers:

1) an underpayment of premium by the Policyholder, the Policyholder will be obligated to remit, in a timely manner, the underpayment amount; or
2) an overpayment of premium, The Company will return any overpayment amount in a timely manner;

for the previous [2 year period.]

[Dividends: As long as a Certificate is in force, the Certificate owner will receive the dividends We declare, if any, in cash annually.] **9**

[Right to Vote: The Company is a mutual company. The Policyholder may vote at the annual election of directors if the Policyholder has one or more policies issued by The Company in force. The annual election is held at Our Home Office in Madison, Wisconsin, on the fourth (4^{th}) Friday in April.] **10**

[**Not in Lieu of Worker's Compensation:** This Policy does not satisfy any requirement for worker's compensation insurance.]

Time Period

All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Incorporation Provision

The Certificate(s) of Insurance [and Riders and Policy Changes] listed below are attached to, incorporated in and made a part of, this Policy.

[Certificate of Insurance	Applicable to:	Effective Date of Incorporation	Termination Date
XXXX	All Eligible Persons	January 1, 2004	January 1. 2005

Rider	Applicable to:	Effective Date of Incorporation	Termination Date
XXXX	All Eligible Persons	January 1, 2004	January 1. 2005

Policy Changes	Applicable to:	Effective Date of Change	Termination Date
Policy Page Added: XXX	All Eligible Persons	January 1. 2004	January 1, 2005
Policy Page Deleted: XXX	All Eligible Persons	January 1. 2004	]

The provisions found in the Certificate will control the benefit plan, period of coverage, exclusions, claims and other general policy provisions pertaining to state insurance law requirements.

Policy Modifications

[**Policy Modifications:** The Policy is amended as follows:

The initial monthly premium rates for Class 3 will be $ for each $1,000 of Basic Life Insurance and $ for each $1,000 of Supplemental Life Insurance.

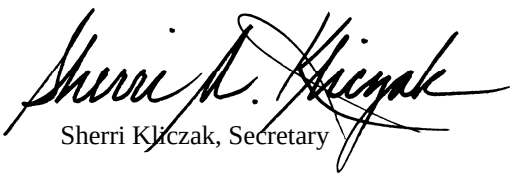
The Rate Guarantee Period for Class 3 will be:

Basic Life Insurance	3 months
Supplemental Life Insurance	3 months

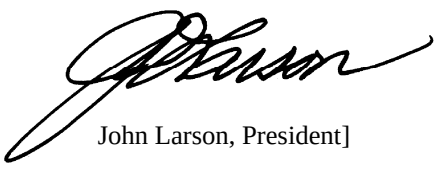
In all other respects, The Policy remains the same.

[RIDER: This rider, issued [January 1, 2004], forms a part of Policy No. [XXXX] issued to [**Policyholder**]. It is effective [June 1, 2004]. It does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for **The Company [**



Sherri Kliczak, Secretary



John Larson, President]

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

GROUP INSURANCE APPLICATION

Administered by: AlwaysCare

[Application is hereby made to National Guardian Life on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

Once approved, the application will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless written notice of a different effective date is sent.

If this application is not approved, no insurance is in effect at any time, and any deposit premium AlwaysCare has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): $ _____

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective.]

[Legal Name of Group_____

Physical Address _____

City\State\Zip _____

Billing Address (If different) _____

City\State\Zip _____

Federal Tax ID _____

Employees: _____ # Eligible: ____ # of Employees with Dependents: _____

Group Effective Date: _____ /_____ / _____]

[Contact for Administration & Eligibility:

_____

Phone: (_____)_____

Fax: (_____)_____

E-mail Address: _____]

[Contact for Billing _____

Phone: (_____)_____

Fax: (_____)_____

E-mail Address: _____]

Plan Selection:

[☐ **Dental Insurance** ☐ **Policy Year** ☐ **Calendar Year**

☐ **Vision Insurance**

☐ **Hearing Rider** (where applicable):

Attached to: ☐ Dental ☐ Vision

☐ **Basic Life (Employer Funded)**

☐ **Supplemental / Voluntary Life**

☐ **AD&D**

☐ **Dependent Life**

☐ **Short Term Disability**

☐ **Long Term Disability**

☐ **Other**_____ **]**

[Policyholder (Employer) contributions:]

[Dental	$_____	per month or ____ % of premium
Vision	$_____	per month or ____ % of premium
Basic Life and AD&D	$_____	per month or ____ % of premium
Supplemental / Voluntary Life and AD&D	$_____	per month or ____ % of premium
Short Term Disability	$_____	per month or ____ % of premium
Long Term Disability	$_____	per month or ____ % of premium]

[Eligibility: Permanent, full-time employees working 30 hours (Standard) or _____ (other) per week are eligible for coverage.
An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.
An eligible dependent must be less than ____ yrs. old or less than _____ yrs. old if a full-time student. Coverage becomes effective the first of the month following eligibility.

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Participation: Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.

I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of full-time employees/members of this group. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

Monthly Administration Fee: I understand there is a **$5.00** monthly administrative billing charge for groups with less than 10 employees enrolled.]

NVI/NDN Grp App 04/08

[IMPORTANT NOTES:
Unless agreed otherwise, membership cards, welcome letters and coverage summaries are printed and provided in a single package following group approval. The certificate of coverage, group policy, administration manuals and other information will be provided on a customized, group-specific CD-ROM to enable the Employer to distribute as needed via email or printouts to all enrolled employees. Employees may also print ID Cards and certificates by visiting our website at www.AlwaysCareBenefits.com.]

[Please send Membership Materials and Enrollment Materials to (CHECK ONE):
☐ Group Attn: _____Phone: (_____)_____
☐ Broker or Agent

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

The applicant understands that the requested group insurance will:

a. be issued only if the requested insurance is acceptable to National Guardian Life (the Company) and is legally permissible;
b. be issued under a group Policy or Policies in the language customarily used by the Company;
c. be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
d. be subject to all exclusions and limitations of the policy; and take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The applicant agrees not to:

a. collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
b. distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant Signature: _____ _____/_____/_____
Name Title Date

National Guardian Representative: _____ _____/_____/_____]
Date

[Agent (if applicable)	Tax I.D. Number
Firm Name (if applicable)	National Guardian Life Insurance Company appointment on file ☐Yes ☐ No **(Please attach Appointment Paperwork if not appointed)**
Address City/State/Zip	Phone Fax Email Address]

TO BE COMPLETED BY ALWAYSCARE BENEFITS

[Group Set Up Information
Group Code: _____
SIC Code: _____

Account Management Approval
Account Manager:_____
Signature_____ Date ____/____/_____]

Notes:

Administered by: AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by:[AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)]
[7800 Office Park Blvd., Baton Rouge, LA 70809-7603,(225)926-2888 or 1-888-729-5433]

EMPLOYEE INFORMATION **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

Employer Name	Group Number	Location	Effective Date

☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone

[COMPLETED BY EMPLOYER]

[Date of Hire]	[☐ Full time ☐ Part time If part time: Hrs worked per week: _____]	[Occupation]	[Class]

[Salary $: _____ ☐ Yearly ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly ☐ Hourly]

FAMILY INFORMATION (Only those eligible may be enrolled.) **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Unmarried child/ FT student/ handicapped? Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No

[BENEFIT ELECTIONS (Employer determines benefits available for election):]

[☐ **Dental**
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____]

[☐ **Vision**
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____]

[☐ **Basic Life / AD&D**
- Employee ☐ Elect ☐ Decline
- Spouse ☐ Elect ☐ Decline
- Children ☐ Elect ☐ Decline]

[☐ **Supplemental / Voluntary Term Life / AD&D**
- Employee ☐ Elect ☐ Decline $_____ or _____ X annual salary
- Spouse ☐ Elect ☐ Decline $_____
- Children ☐ Elect ☐ Decline $_____]

[☐ **Short Term Disability**
☐ Elect ☐ Decline
If Buy-Up Available: ☐ Elect ☐ Decline]

[☐ **Long Term Disability**
If Buy-Up Available: ☐ Elect ☐ Decline]

[Beneficiary Information (Complete ONLY for Life or AD&D):]

[Primary Beneficiary:	Relationship:	Date of Birth:
Contingent Beneficiary:		]

In the past 12 months, have you had continuous group coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no
If yes, please provide: Policyholder _____ and Insurance Company _____
Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage
☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements on page 2 and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from National Guardian Life Insurance Company.

Your signature X_____ Date signed _____

Administered by:
AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by:[AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)]
[7800 Office Park Blvd., Baton Rouge, LA 70809-7603,(225)926-2888 or 1-888-729-5433]

[I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. If I refuse [dental or vision] coverage, I and/or my dependents may enroll later [but this will affect the level of benefits]. [If I refuse life and/or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by National Guardian Life Insurance Company]. If I refuse coverage, I cannot enroll after retirement.]
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage. I agree National Guardian Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I authorize National Guardian Life Insurance Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by National Guardian Life for claims administration [and determining eligibility for life and disability coverage]. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by National Guardian Life Insurance Company only as allowed by law.]
- [NOTE For Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.]
- [For Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.]

A copy of this form will be as valid as the original.

After this form is completed and signed, make two copies and send the original to:

National Guardian Life Company
c/o AlwaysCare Benefits
P.O. Box 98100
Baton Rouge, LA 70898-9100

• Employer – copy of Page 1 and Page 2

• Employee – copy of Page 1 and Page 2

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Administered by: AlwaysCare

PERSONAL HEALTH INFORMATION

Thank you for choosing AlwaysCare Benefits, Inc. (a Starmount Life Insurance Company) and National Guardian Life Insurance Company. All sections of this form must be completed and received by AlwaysCare within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with National Guardian Life or AlwaysCare. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1 –Employer Details *(to be completed by Employer)*	**PLEASE PRINT CLEARLY**
Employer Name:	Policy Number:
Division *(if applicable):*	
Employer Mailing Address (Street, City, State, Zip Code):	
Benefits Contact Name: (First, Last)	
Benefits Contact Email Address:	Benefits Contact Phone: ( ) -

Section 2 – Applicant Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name: (First, MI, Last)

Base Annual Earnings*:	Social Security Number: - -	Date of Hire (mm/dd/yyyy): / /

* Base annual earnings as described in the contract with National Guardian Life Insurance Company.

Coverage Details

- Check the box(es) next to each row of the applicant's existing or new employer-sponsored coverage.
- Enter the amount of any **existing** coverage (including Guarantee Issue*) in **Current Coverage**. Please include the amount of Employee Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** by the applicant that requires Medical Underwriting.
- If the applicant is enrolling after his/her initial eligibility, check **Late Entrant** as the **Reason for Medical Underwriting**, if not, check **Other** as the reason.

		Reason for Medical Underwriting	**Current Coverage**	**Additional Coverage Requested**
		Enter all amounts as dollars or as percentages of Base Annual Earnings		
	Life Insurance Coverage			
☐	Employee Basic Life	☐ Late Entrant ☐ Other		
☐	Employee Supplemental or Voluntary Life	☐ Late Entrant ☐ Other		
☐	Spouse Basic Life	☐ Late Entrant ☐ Other		
☐	Spouse Supplemental or Voluntary Life	☐ Late Entrant ☐ Other		
	Disability Insurance Coverage			
☐	Short-Term Disability	☐ Late Entrant ☐ Other		
☐	Long Term Disability	☐ Late Entrant ☐ Other		

* Guarantee Issue is the maximum amount of coverage – as defined in the contract with National Guardian Life Insurance Company – that does not require an applicant to provide proof of good health.

Is the employee requesting more than $15,000 of coverage for a child? ☐**Yes** ☐ **No**	Number of Children:	Amount Requested Per Child: $

Employees: Please complete pages two and three.
It should take you about 7 to 10 minutes to complete this form

Employee: First Name_____ **Last Name**_____

Employee Section

Please answer all questions on this page completely and accurately and certify your answers on the next page. **Leaving information blank will result in delays and may result in your file being closed.** AlwaysCare may contact you for additional or missing information.

Section 3 – Employee Information *(Complete even if employee is not applying for coverage)* **PLEASE PRINT CLEARLY**

Home Mailing Address (Street, Apt. #):		City:	
State:	Zip Code:	Employer:	
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In.	Weight_____ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:	

Section 4 –Spouse or Eligible Partner Information *(Complete only if applying for this coverage)* **PLEASE PRINT CLEARLY**

First Name:	Last Name:	Social Security Number - -	
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In.	Weight_____ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:	

Section 5 – Medical Information *(to be completed only by applicants requesting coverage)*

If you or anyone proposed for coverage can answer *Yes* to any of Questions 1 – 6 below, check the appropriate box and provide **additional details in Section 6. Residents of Florida, Maine, Minnesota, North Carolina, Vermont or Wisconsin, please review the condition specific wording required by your state on page 4 of this form prior to answering these questions.**

1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	☐ Employee	☐ Spouse
2. Within the past 2 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	☐ Employee	☐ Spouse
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	☐ Employee	☐ Spouse
4. Are you currently pregnant? _____ If yes, what was your pre-pregnancy weight?_____ lbs	☐ Employee	☐ Spouse
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immune deficiency disorder?	☐ Employee	☐ Spouse

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below?

	Employee	Spouse		Employee	Spouse
Heart Related Surgery or Heart Attack	☐	☐	Crohn's Disease	☐	☐
Stroke	☐	☐	Kidney Failure/Dialysis	☐	☐
Heart Disease (excluding high blood pressure & heart murmur)	☐	☐	Hepatitis (excluding Hepatitis A)	☐	☐
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysms, or deep vein blood clots)	☐	☐	Diabetes	☐	☐
Chronic Obstructive Pulmonary Disorder (COPD)	☐	☐	Knee Disorder, Injury, or Surgery	☐	☐
Emphysema	☐	☐	Back or Neck Disorder, Injury, or Surgery	☐	☐
Adjustment Disorder	☐	☐	Joint/Ligament Disorder, Injury, or Surgery	☐	☐
Bipolar Disorder	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression (single episode)	☐	☐	Multiple Sclerosis (MS)	☐	☐
Depression (multiple episodes)	☐	☐	Amyotrophic Lateral Sclerosis (ALS)	☐	☐
Psychotic/Personality Disorders	☐	☐	Muscular Dystrophy	☐	☐
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	☐	☐	Arthritis	☐	☐
Cancer (excluding Basal Cell Carcinoma)	☐	☐	Fibromyalgia	☐	☐
Cirrhosis	☐	☐	Chronic Fatigue Syndrome	☐	☐
Ulcerative Colitis	☐	☐	Sleep Apnea	☐	☐

Employee First Name_____ **Last Name:** _____

Section 6 – Additional Details: If you or anyone proposed for coverage checked any box next to Questions 1 – 6, please provide details in the space below. If you need more space, please attach, sign and date an additional sheet.

Question # or Condition	Applicant Name	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name and Phone #

Section 7 – Certification Statement *(To be completed by all applicants)*

By checking this box: ☐ **Employee** ☐ **Spouse**

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 8 – Fraud Statement *(To be completed by all applicants)*

I hereby certify that the above statement and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statement and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This information may be used by AlwaysCare (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage. I acknowledge that I have read the disclosure notice on the last page of this application.

Notice: *Anyone applying for coverage is required to notify National Guardian Life and AlwaysCare in writing at the address below of any changes in their medical condition to the best of their knowledge between the date you sign this form and the date the coverage is approved.*

_____ ____/____/____ _____ ____/____/____

Employee's Signature or Legal Representative/ Relationship to Employee **(Required)** — **Date Signed**

Spouse's (or Eligible Partner's) Signature or Legal Representative/Relationship to Spouse **(Required only if applying for coverage)** — **Date Signed**

Please return the completed Employer and Employee sections to:
National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc.
P.O. 98100
Baton Rouge, LA 70898-9100

If you have any questions or concerns about this form, please call AlwaysCare's Customer Service Department toll-free at 888-729-5433, Ext. 2013, Monday through Friday, 7:30 a.m. – 8:30 p.m. (CST), Saturday, 9:00 a.m. – 3:00 p.m. (CST)**.**

State Specific Information
Please Do Not Return This Page – Retain for Your Records

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTON, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

Florida residents: AIDS/HIV Condition: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Maine residents: You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota residents: YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE: (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

North Carolina residents: AIDS/HIV Condition: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont residents: AIDS/HIV Condition: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Wisconsin residents: AIDS/HIV Condition: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Disclosure Notice
Please Do Not Return This Page – Retain for Your Records

I authorize AlwaysCare Benefits (a Starmount Life Insurance company) and National Guardian Life Insurance Company to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organization, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I understand that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, AlwaysCare and National Guardian Life must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the authorization on the application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: AlwaysCare Benefits, Inc., Privacy Officer, P.O. Box 98100, Baton Rouge, LA 70898-9100.

All policies are underwritten by National Guardian Life Insurance Company*.

*National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian or Guardian Life.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

CERTIFICATE OF INSURANCE

[Policyholder: ABC Policyholder]
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE] **[Participating Entity]**
[Policy Anniversary Date: DATE] **[Account Number: XXXXXXX]**

Administrator: [Insert Administrator Name
Insert Administrator Address]

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President]

[LONG TERM DISABILITY COVERAGE]

[**READ YOUR CERTIFICATE CAREFULLY**
You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.]

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

[**Table of Contents**

Schedule of Insurance

[The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You**.

The benefits described herein are those in effect as of DATE.

Cost of coverage:
Option 1 - You do not contribute toward the cost of coverage under Option 1.
Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) for Coverage: All Full-time and Part-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment:	at least # hours weekly
Part-time Employment:	at least # hours weekly, but less than # hours weekly

Annual Enrollment Period: MONTH & DAY through MONTH & DAY.

Maximum Monthly Benefit: $XXXXXXX

Guaranteed Issue Amount: $XXXXXXX

Minimum Monthly Benefit: the greater of:
1) $ # ; or
2) # % of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

In accordance with Arkansas state law, in no event will the Minimum Monthly Benefit be less than $50.

Initial Benefit Period Percentage:
Option 1: #%
Option 2: #%

Continuing Benefit Period Percentage:
Option 1: #% of Pre-disability Earnings
Option 2: #% of Pre-disability Earnings

The following section is used only in incremental plans:
Maximum Monthly Benefit: The lesser of:
- $5,000;
- 60% of your Pre-disability Earnings; or
- your Scheduled Monthly Benefit.

Minimum Monthly Benefit: $100

Scheduled Monthly Benefit (Monthly Benefit): An amount you elect in increments of $500.

Corresponding Scheduled Monthly Benefit Percentage: Your Scheduled Monthly Benefit divided by your Pre-disability Earnings.

Eligibility Waiting Period for Coverage:
Option 1: X days/weeks/months of continuous service
Option 2: X days/weeks/months of continuous service
You will be eligible for coverage on the first day of the month on or next following the date on which You complete the Eligibility Waiting Period for Coverage.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer in an eligible class under the Prior Policy.

Schedule of Insurance

Elimination Period:
Option 1: X day(s)
Option 2: X day(s)

Maximum Duration of Benefits Table

Age When Disabled	**Benefits Payable**
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months]

Definitions

[Actively at Work means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for [Your usual number of hours.]

[We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.]

Active [Employee] means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.]

Any Occupation means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of:

1) [the product of Your Indexed Pre-disability Earnings and the [Initial] Benefit Period Percentage]; or
2) [the Maximum Monthly Benefit.]]

Bonuses means the [monthly average of monetary] bonuses You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]]

Commissions means the [monthly average of monetary] commissions You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]

[Current Monthly Earnings means [Monthly] earnings You receive from:

1) [the Employer; and
2) other employment;]

while You are Disabled.

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly] Earnings.]

[Current [Monthly] Earnings also includes the pay You could have received for another job or a modified job if:

1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.]

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of Any Occupation as a result of:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.]

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] during the Elimination Period; and
2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must result from:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]

Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period;
2) Your Occupation, for the [24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings;
3) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] after that, [for the next 12 months]; and
4) after that, Any Occupation .

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must be the result of:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]]

[Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] during the

Elimination Period;
2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] [for the 24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings; and
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must result from:
1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]

Elimination Period means the [longer of the] number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable [or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law].

Employer means the [Policyholder].

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.]

Indexed Pre-disability Earnings

means Your Pre-disability Earnings adjusted annually by adding the lesser of:

1) [10%;] or
2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for [12 consecutive months,] provided You are receiving benefits at the time the adjustment is made. [A maximum of [5] adjustments may be made.]

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W].

Mental Illness

means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

[Monthly] Benefit

means a [monthly] sum payable to You while You are Disabled, subject to the terms of The Policy. [Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.]

Monthly Income Loss

means Your Pre-disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits

means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuan to any:

1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the result of membership in or association with any group, association, union or other organization;
4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
6) [mandatory "no-fault" automobile insurance plan;]
7) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any

provincial pension or disability plan; or
d) similar plan or act;

that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or

8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under the Employer's Retirement plan;
2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or
5) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
   d) similar plan or act;

   that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.]

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.]

Participating [Employer]

means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.]

Physician

means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Pre-disability Earnings

means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]:

1) the [monthly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for:
   a) the [X tax] year(s) just prior to the date of Disability; or
   b) the number of months You were employed in this capacity, if less than above period; and
2) [not] contributions You make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section125 plan,

   for the same period as above.

Pre-disability Earnings [does not] include [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital.

Pre-disability Earnings

means, [for specific class description if applicable] Your average [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period:

1) [not] including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense reimbursements for the same period as above.

Pre-disability Earnings

means, [for specific class description if applicable], Your regular [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens],

1) [not] including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions and tips and tokens] overtime pay or expense reimbursements for the same period as above.]

[However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:

1) the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by;
2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.]

[Prior Policy means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, [any necessary and feasible:

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.]

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].]

[Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) [a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.]

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

[Substance includes alcohol and drugs but excludes tobacco and caffeine.]

The Policy means the policy which We issued to [The Policyholder under the policy number] shown on the face page.

Tips [and Tokens] means the [monthly average of monetary] tips and tokens You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]

Definitions

Trust means [the trust fund established by XXX.]

We, Our, or Us means [the insurance company named on the face page of The Policy.]

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

[If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.]

[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]

You or Your means the person to whom this certificate is issued.]

Eligibility and Enrollment

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:

1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage.

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]

Enrollment: *How do I enroll for coverage?*

[For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll.] To enroll [for coverage]You must:

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll [or if You enroll for a Monthly Benefit Amount greater than the Guaranteed Issue Amount]:]

1) You must give Us Evidence of Insurability satisfactory to Us; and
2) [You may only enroll:
   a) during an [Annual Enrollment Period] designated by the Policyholder; or
   b) within [31 days] of the date You have a Change in Family Status.]

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability may include, but will not be limited to:

1) [a completed and signed application approved by Us;
2) a medical examination;
3) an attending Physician'sd statement; and
4) any additional information We may require.]

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

1) [You get married [or You execute a domestic partner affidavit];
2) You and Your Spouse divorce [or You terminate a domestic partnership];
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse [or domestic partner] dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.]

Period of Coverage

Effective Date: *When does my coverage start?*

[If You are not required to contribute toward The Policy's cost,] Your coverage will start:

1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or
2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.]

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:

1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then;
2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible;
3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or]
4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.]

Deferred Effective Date: *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;]

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day.

[Changes in Coverage: *Can I change my benefit option?*

[You may change Your benefit option only:
1) during an Annual Enrollment Period; or
2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:
1) [the first day of the month following the Annual Enrollment Period;] or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:
1) the date You enroll for the change; or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:
1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.]]

Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:
1) the Deferred Effective Date provision; and
2) Pre-existing Conditions Limitations.]

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*

[If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Monthly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the [Monthly] Benefit which was paid by the Prior Policy; or
2) the [Monthly] Benefit provided by The Policy.]

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [monthly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination:
When will my coverage stop?

Your coverage will end on the earliest of the following:

1) [the date] The Policy terminates;
2) [[the date] The Policy no longer insures Your class;]
3) [the date] premium payment is due but not paid by the Employer;
4) [the last day of the period for which You make any required premium contribution;]
5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;]
6) [the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason;
7) [the date Your Employer ceases to be a Participating Employer];

unless coverage is extended under the Continuation Provisions.

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium [by the Employer;] and
3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.]

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.]

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.]

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.]

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]]

Period of Coverage

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) [during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.]

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You:

1) [after the Elimination Period; and
2) for as long as benefits are payable.]

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Conversion Right:
If my coverage under the Policy stops, do I have a right to conversion?

If Your insurance terminates because:

1) Your employment ends [for a reason other than Your retirement]; or
2) You are no longer in an eligible class;

and if:

1) [You have been continuously insured for at least [12 consecutive months] under The Policy or under both this Policy and the Prior Policy;]
2) [You are under the Policy Age Limit, if any is shown in the Schedule of Insurance;]
3) a Disability is not preventing You from performing duties of Your Occupation;
4) [the insurance for Your class, or] The Policy has not terminated;
5) [You are not eligible for coverage under The Policy under another class; and]
6) You are not eligible or covered for similar benefits under another group policy [or an individual policy];

then You are eligible to enroll for personal insurance under another group policy called the group long term disability conversion policy.

How do I convert my Coverage?

To obtain coverage under the group long term disability conversion policy, You must:

1) send Us a written enrollment request; and
2) pay the required premium and enrollment fee for the conversion policy;

within [31 days] of the termination of Your insurance.

If You meet the preceding conditions, We will issue You a certificate of insurance under the group long term disability conversion policy. Such coverage will:

1) be issued without Evidence of Insurability;
2) be on one of the forms then being issued by Us for conversion purposes; and
3) be effective on the day following the date Your insurance under The Policy terminates.

The coverage available under the conversion policy may differ from The Policy. We will determine the terms of the group long term disability conversion policy, including:

1) the type and amount of coverage provided; and
2) the premium payable;

based on the kinds of insurance provided by the group long term disability conversion policy at the time such enrollment request is made.

Benefits

Disability Benefit: *When do I qualify for Disability Benefits?*

We will pay You a Monthly Benefit if You:

1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness And Substance Abuse Benefits: *Are benefits limited for Mental Illness [or Substance Abuse?]*

If You are Disabled because of:

1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;
3) alcoholism [which is under treatment]; or
4) [the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance];

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

[Benefits will be payable for a total of [24 months,] unless at the end of the [24 month] period:

1) You are confined in a hospital or other place licensed to provide medical care for the disabling condition, in which case:
   a) benefits will continue during the confinement; and
   b) if You are still Disabled when discharged, benefits will continue for a recovery period of up to [90 days;] and
   c) if You become re-confined during the recovery period for at least [14 consecutive days,] benefits will continue during the confinement and another recovery period of up to [90 days;]

or

2) You continue to be Disabled and, [within 7 days] become confined in a hospital, or other place licensed to provide medical care, for the disabling condition for at least [14 consecutive days,] in which case benefits will be paid while You are so confined.]

Substance Abuse Limitation: *Are benefits limited for alcoholism or Substance Abuse?*

If You are Disabled because of:

1) alcoholism [under treatment]; or
2) the non-medical use of narcotics, [sedatives, stimulants, hallucinogens, or any other such substance];

then, subject to all other Policy provisions, benefits will be payable for [as long as] You are:

1) confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) actively participating in a rehabilitative program approved by Us.

Recurrent Disability: *What happens if I recover but become Disabled again?*

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are [less than one-half (1/2) the number of days of Your Elimination Period.]

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within [6] months of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [6] months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a New Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit: *How are my Disability benefits calculated [during the Initial Benefit Period]?*

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefit [during the Initial Benefit Period] as follows:

1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage ;
2) compare the result with the Maximum Benefit ; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

How are Disability benefits calculated?

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefits as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage; and from this product subtract all Other Income Benefits; and
3) identify the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows:

1) multiply Your Pre-Disability Earnings by the [Initial] Benefit [Period] Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The [12 consecutive month] period will start on the last to occur of:

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, [during the Initial Benefit Period,] We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Calculation of Monthly Benefit: Return to Work Incentive*: How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows:

1) multiply Your Pre-disability Earnings by the Benefit Percentage;
2) multiply Your Pre-disability Earnings by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit during this period. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

If You are Disabled, but You are not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

During the Continuing Benefit Period, if [You are not receiving benefits under the Return to Work Incentive, but] You are receiving benefits under Social Security Disability or Social Security Retirement plans, or an alternative plan for federal, state or municipal employees, We will determine Your Monthly

Benefit as follows:

1) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

During the Continuing Benefit Period, if You are not receiving benefits [under the Return to Work Incentive, or] under Social Security Disability or Social Security Retirement plans or an alternative plan for federal, state or municipal employees, We will determine Your Monthly Benefit as follows:

1) multiply Your Pre-disability Earnings by the Continuing Benefit Period Percentage;
2) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage, and deduct all Other Income Benefits; and
3) deduct all Other Income Benefits from the Maximum Benefit.

The result of the calculation giving the least amount is Your Monthly Benefit.

Calculation of Monthly Benefit: *What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*

If the sum of Your [Monthly Benefit, Current Monthly Earnings and Other Income Benefits] exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess.

[However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.]

[If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.]

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows:

1) compare the Scheduled Monthly Benefit with the Maximum Benefit; and
2) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The [12 consecutive month] period will start on the last to occur of:

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Corresponding Scheduled Monthly Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*

If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Denial of Social Security Benefits:
After the Initial Benefit Period expires, is there any allowance if I am ineligible for Social Security?

If Your Disability prevents You from performing the Essential Duties of Any Occupation, but Your claim for disability benefits under The United States Social Security System, or an alternative plan for federal, state or municipal employees:

1) was denied because You have not worked under these systems long enough to be eligible for disability benefits, Your Monthly Benefit during the Continuing Benefit Period will be calculated using the Initial Benefit Period Percentage; or
2) is still pending at the time the Initial Benefit Period expires, benefits may be paid at the Initial Benefit Period Percentage until the earlier to occur of:
    a) the 12th month following the expiration of the Initial Benefit Period; or
    b) the final adjudication of Your claim for Social Security disability benefits.

Termination of Benefit Payment:
When will my benefit payments end?

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]]
4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
5) the date of Your death;
6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.]
7) [the last day benefits are payable according to the Maximum Duration of Benefits Table; or]
8) [the date Your Current Monthly Earnings:
   a) are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation [or a Reasonable Alternative]; or
   b) [are greater than the lesser of: the product of Your [Indexed] Pre-disability Earnings and the [Initial] Benefit [Period] percentage; or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;]]
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
   a) [modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
   b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
   c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
   d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

   provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation;] or
11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
   a) You were receiving them prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in Rehabilitation?*

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1) Family Care means the care or supervision of:
   a) Your children under age [13]; or
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) the maximum monthly deduction allowed for each qualifying child or family member is:
   a) [$350] during the first [6] months of Rehabilitation ; and
   b) [$175] thereafter;
   but in no event may the deduction exceed the amount of Your monthly earnings;
3) Family Care Credits may not exceed a total of [$2,500] during a calendar year;
4) the deduction will be reduced proportionally for periods of less than a month;
5) the charges for Family Care must be documented by a receipt from the caregiver;
6) the credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitation program; or
   b) Family Care Credits for [24] months have been deducted during Your Disability; and
7) no Family Care provided by a someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed [80%] of Your [Indexed] Pre-disability Earnings.

Cost-Of-Living Adjustment: *How do my benefits keep pace with inflation?*

We [will] adjust Your Monthly Benefit for increases in the cost-of-living if:

1) You have been Disabled for [12 consecutive months]; and
2) [You are receiving benefits;] [and
3) Your Current Monthly Earnings are less than or equal to 20% of Your Pre-disability Earnings;]

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.]

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

1) determining the lesser of:

a) [3%]; or

b) [1/2] the percentage change in the Consumer Price Index;

2) multiplying the resulting percentage (%) times the Monthly Benefit for Disability being received; and
3) adding the resulting amount to Your Monthly Benefit.

When will the Cost-of-Living Adjustments end?

You will not receive a Cost-of-Living Adjustment after:

1) You cease to be Disabled; [or
2) You have received [5] adjustments;] or
3) The Policy terminates.

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered].

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability* Benefits?

If You were receiving a Monthly [Disability] Benefit at the time of Your death [and You had been receiving such benefits [for at least 12 months]], We will pay a [Survivor Income Benefit], when We receive proof satisfactory to Us:

1) of Your death; and
2) that the person claiming the benefit is entitled to it.

[We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.]

[[We will pay the Survivor Income Benefit:

1) to the beneficiary You designated; or
2) if no beneficiary has been designated:]
   a) to Your Surviving Spouse; or
   b) if no Surviving Spouse, in equal shares to Your Surviving Children;
   c) [if no Surviving Spouse or Surviving Children, to Your estate.]

[If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.]

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

[The Survivor Income Benefit [will be equal to [3] times your Monthly Benefit/is calculated as [3] times the lesser of]:

1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
2) The Maximum Monthly Benefit.]

[To designate or change Your designation of beneficiary, You must file a written notice with Us on any form satisfactory to us. Whether You are living or not, any change will relate back and take effect as of the date You signed the written notice. We are not liable for payment of benefits made before receiving written notice.]

Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. ["Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.]

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance who are under age [19].The term Surviving Children will also include any other children related to You by blood or marriage [or domestic partnership] and who:

1) lived with You in a regular parent-child relationship; and
2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

[In the event that You are diagnosed with a Terminal Illness while You are:

1) eligible for a Monthly Benefit under the Policy; and
2) at least [6] Monthly Benefit Payments remain payable to You;

We will pay the Survivor Income Benefit to You on an accelerated basis in one lump sum if:

1) [You submit a request that the Survivor Income Benefit be paid on an accelerated basis; and
2) We receive proof that You have been diagnosed with a Terminal Illness.

If the Survivor Income Benefit is paid on an accelerated basis, no additional benefit will be payable under this benefit upon Your death.]

[Terminal Illness or Terminally Ill means a life expectancy of [6] months or less.]

Extended Earnings Protection Benefit: *Will benefits continue to be paid after my return to work if my earnings are less than Pre-disability Earnings?*

This benefit protects Your earnings level after You have returned to work following a period of Disability. To qualify for this Extended Earnings Protection Benefit, You must:

1) have been Disabled under The Policy and received a Monthly Benefit from Us;
2) now be working [Full-time] for the Employer [or another employer;]
3) be performing all the Essential Duties of Your Occupation [or another occupation;]
4) as a result of having been so Disabled, be currently earning less than [80%] of Your Pre-disability Earnings; and
5) provide to Us each month, satisfactory proof of Your Current Monthly Earnings.

The Extended Earnings Protection Benefit will be the lesser of:

1) the Maximum Monthly Benefit ; or
2) Your Monthly Income Loss multiplied by the [Initial] Benefit [Period] Percentage.

The Extended Earnings Protection Benefit will end on the earliest of:

1) the date benefits have been payable for a maximum duration of [24] months;
2) the date You are earning at least [80%] of Your Pre-disability Earnings; or

the date You fail to submit to Us satisfactory proof of Your Current Monthly Earnings.

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

1) Your Disability is covered by this Policy;
2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such workplace modification shall not exceed the amount equal to the amount of the Maximum Monthly Benefit.

We have the right, at Our expense, to have You examined or evaluated by:

1) a Physician or other health care professional; or
2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

1) the proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Employee.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this Policy.

Pension Contribution Benefit*: Does The Policy also cover contributions to a Pension Plan?*

[If You:

1) become Disabled while You are covered under this Pension Contribution Benefit;
2) remain Disabled for [365 days] of one continuous period of Disability; and
3) are receiving a Monthly Benefit under The Policy;]

We will pay a monthly Pension Contribution Benefit to the trustee or administrator of Your Pension Plan for deposit to Your pension account. The Pension Contribution Benefit will be [the least of:

1) [15%] of Your monthly Pre-disability Earnings;
2) [$2,500];
3) the amount of the average monthly tax deferred contributions the Employer made to Your Pension Plan during the [12 calendar months] prior to becoming Disabled.]

We will make payments under this benefit according to the rules and regulations of the Internal Revenue Service and the provisions of Your Pension Plan. We will make any such payment that cannot be paid to the trustee or administrator of Your Pension Plan to a deferred annuity account designated by You.

No Pension Contribution Benefit will be payable after Your Monthly Benefit terminates.

Pension Plan means, for the purpose of this Pension Contribution Benefit, a qualified defined contribution pension Plan, profit sharing Plan, or other Plan approved by Us, in which You are participating as a result of Your employment with the Employer.

Infectious And Contagious Disease Benefit: *If it is disclosed that I carry an Infectious and Contagious Disease, will The Policy cover the income lost as the result of limitations placed on my license or reduced patronage?*

You will be eligible to receive an Infectious and Contagious Disease Benefit when You have been covered by this benefit for a period of [12 months], and You provide verification that:

1) You carry an Infectious and Contagious Disease; and
2) You first tested positive for the Infectious and Contagious Disease after the effective date of this benefit; and
3) You are not Disabled but one or more of the following has happened:
   a) Your license to practice Your Occupation has been revoked; or
   b) You or Your license have limitations or restrictions imposed, and as a result You are unable to perform all of the Essential Duties of Your Occupation; or
   c) it has been disclosed that You are infected with an Infectious and Contagious Disease; and
4) throughout a period of time equal in length to the [Elimination Period,] You have suffered a loss of earnings in excess of [20]% of Your Pre-disability Earnings immediately prior to disclosure; and
5) You have never refused to be immunized against the Infectious and Contagious Disease for which You are claiming this benefit.

What qualifies as an Infectious and Contagious Disease?

To qualify as an Infectious and Contagious Disease, a disease must be:

1) categorized by the Center for Disease Control as Infectious and Contagious; and
2) life threatening to You or persons with whom You may come in contact.

What will my monthly benefit be?

[We calculate the benefit as the lesser of;

1) the Maximum Monthly Benefit; or
2) Your earnings loss multiplied by the [Initial] Benefit [Period] Percentage.

Your earnings loss is determined by deducting Your Pre-disability Earnings after disclosure from Your Pre-disability Earnings prior to disclosure.]

How long may an Infectious and Contagious Disease Benefit be paid?

We will stop paying this benefit on the earliest of:

1) the date Your Pre-disability Earnings are equal to or greater than [80]% of Your Pre-disability Earnings prior to disclosure;
2) the date You die;
3) the date You become eligible for Disability benefits under the terms of this Policy;
4) the date We determine You have not made every effort to continue to work in Your Occupation [on a full-time basis];
5) the date You no longer participate with Us in seeking and applying for suitable alternate work based on Your training, education, experience, and comparable income;
6) the end of the Maximum Duration of Benefits [Table/Payable] of The Policy; or
7) [the end of [2 years] from the date this benefit begins.]

Activities of Daily Living Benefit:
What is the Activities of Daily Living Benefit?

We will pay You the Activities of Daily Living Benefit if:

1) a Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform [two or more] Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
   a) [during or after the Elimination Period, and]
   b) for at least [30 consecutive days;] and
3) the Disability and such impairment or inability begins while You are covered under this benefit.

The Activities of Daily Living Benefit will be [10% of Your Monthly Income Loss, but not greater than the lesser of:

1) [$5000]; or
2) the Maximum Monthly Benefit.]

[The maximum payment period for this benefit will be [X years].]

[We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Activities of Daily Living Benefit for each day of covered loss.]

The Activities of Daily Living Benefit will not:

1) be reduced by Other Income Benefits;
2) increase or reduce other benefits under The Policy; [or
3) be subject to the Cost of Living Adjustment.]

You are not restricted in any way as to Your use of this Activities of Daily Living Benefit.

We will stop paying You the Activities of Daily Living Benefit on the date:

1) Your Monthly Benefit terminates;
2) You are not Cognitively Impaired and You are able to perform [five or more] ADLs;[or
3) You reach the maximum payment period shown in this benefit.]

Cognitively Impaired means You suffer severe deterioration, or loss of:

1) memory;
2) orientation; or
3) the ability to understand or reason;

so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.

Activities of Daily Living (ADLs) means the following functions performed with or without equipment or adaptive devices:

1) bathing Yourself by being able to either:
   a) wash Yourself in a tub or shower devices; or
   b) give Yourself a sponge bath;
2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
4) transferring from bed to chair or wheelchair; or
5) bladder and bowel control by being able to either:
   a) voluntarily control bowel and bladder function; or
   b) maintain a reasonable level of person hygiene, if You are not so able; and
6) feeding Yourself, once the food has been prepared and made available to You.

Benefits

Accidental Dismemberment and Loss of Sight Benefit: *What benefits are payable for dismemberment or loss of sight due to an Injury?*

If, while covered under The Policy, You sustain an accidental bodily injury, which results in any of the following Losses within [90 days] after the date of accident, We will pay the Monthly Benefit, after the Elimination Period, for at least the number of months shown opposite the Loss.

For Loss of	Minimum Number of Monthly Benefit Payments
[Both Eyes	46
Both Hands or Both Feet	46
One Hand and One Foot	46
One Hand and One Eye	46
One Foot and One Eye	46
One Hand or One Foot	23
One Eye	15
Thumb and Index Finger of Either Hand	12]

[**Loss** means, with regard to:

1) hands and feet, actual severance through or above wrist or ankle joints;
2) eyes, entire and irrecoverable Loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints.]

If You incur more than one of the listed Losses as the result of the same accident, the number of monthly benefit payments that You will receive will be limited to the Loss for which the greatest number of monthly benefit payments are shown in the above Schedule.

Benefits may continue to be payable to You after the Minimum Number of Monthly Benefit Payments have been made, if You remain Disabled. If You die after the Elimination Period, but before the minimum number of monthly benefit payments have been made, the remaining monthly benefit payments will be made to Your estate.

Business Protection Benefit: *Are additional Disability Benefits paid to compensate for business revenue lost when I am Disabled?*

We will pay a [Monthly] Business Protection Benefit to the Employer if You:

1) are actively engaged on a full-time basis in the business of the Employer, and fall within a class of persons that is covered by The Policy, and You are:
   a) the sole proprietor of the Employer if the Employer is a sole proprietorship; or
   b) a general partner of the Employer if the Employer is a partnership; or
   c) a Member of a Limited Liability Company if the Employer is a Limited Liability Company; and
2) become Disabled while You are covered under this Business Protection Benefit; and
3) remain Disabled for the longer of:
   a) the Elimination Period; or
   b) [90] consecutive days; and
4) are receiving a [Monthly] Benefit for the Disability under the group insurance policy.

We calculate the [Monthly] Business Protection Benefit as the [lesser of:

1) [15]% of Your [Pre-disability Earnings]; or
2) [$2,500].]

Is a benefit paid if I am Disabled and Working?

[If You are Disabled and Working, We will proportionately reduce the Business Protection Benefit according to the following formula:

Business Protection Benefit Payable = $\frac{(A - B) \times C}{A}$

where

A = Your Pre-Disability Earnings

B = Your current [Monthly] earnings

C = The Business Protection Benefit payable if You were Totally Disabled.]

How long will this benefit be paid?

We will stop paying the Business Protection Benefits on the earliest of:

1) [the date You cease to be Disabled;
2) the date [12 monthly] benefits have been paid under this Benefit;
3) the date You cease to be the proprietor, a partner, or a [Member,]if applicable, of the Employer; or
4) the date You die.

In no event will this benefit continue to be payable beyond a date shown in the Termination of Benefit Payment provision.]

Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:
The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.

[**Rehabilitation Bonus:** *What happens if I successfully complete an approved program of Rehabilitation?*

If You successfully complete an approved program of Rehabilitation, You will be eligible for an additional benefit equal to [1] times Your Monthly Benefit.

The benefit will be subject to all applicable terms and conditions of the Policy. We will pay the benefit in one lump sum.]

Exclusions and Limitations

Exclusions: *What Disabilities are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused [or contributed to by] war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused [or contributed to] by an intentionally self-inflicted [Injury];
6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer;
7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for [365] consecutive day(s)] while insured under The Policy; or
2) [You have been continuously insured under The Policy for [365] consecutive day(s)].

Pre-existing Condition means:

1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the [730] day period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.]

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim.

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within [15 days] after We receive a notice of claim.]

Proof of Loss: *What is Proof of Loss?*

[Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current [Monthly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.] All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss*: When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than [1 year] after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request.

Claim Payment*: When are benefit payments issued?*

When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as Proof of Loss satisfactory to Us is received].

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid:
To whom will benefits for my claim be paid?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to [$1,000] to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial:
What notification will I receive if my claim is denied?

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal:
What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

1) You must request a review upon written application within:
   a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

[Social Security: *When must I apply for Social Security Benefits?*

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We reserve the right to reduce Your [Monthly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly] Benefit by the estimated amount.
Your [Monthly] Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly] Benefit by an estimated amount and:

1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision .

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) [retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.]

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.]

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) [You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and

e) Your estate.]

2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and

pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Reimbursement: *What are the Company's Reimbursement Rights?*

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

a) a legal judgment;
b) an arbitration award; or
c) a settlement or otherwise;

You must reimburse Us for the lesser of:

a) the amount of payment made or required to be made by Us; or

the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than [60 days] after the date proof of loss is given; or
2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.]

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

[Rider Language This rider forms a part of [The Policy to which it is attached] and [all] certificates given in connection with The Policy.

This rider becomes effective [on the later to occur of:

a) the effective date of the Policy or certificate to which this rider is attached; or
b) the first day of the month on or next following the date e accept Your application and required premium.]

[In consideration of the required additional premium and submission of satisfactory evidence of insurability, the following benefit is added to The Policy and certificates:]

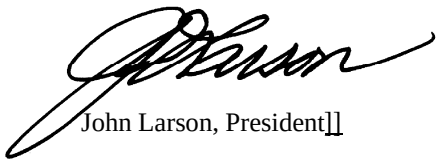
In all other respects, The Policy and certificates remain the same.

Signed for **National Guardian Life Insurance Company**

[

Sherri Kliczak, Secretary

[



John Larson, President]]

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

[Policyholder: ABC Policyholder]
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE] **[Participating Entity]**
[Policy Anniversary Date: DATE] **[Account Number: XXXXXXX]**

Administrator: [Insert Administrator Name
Insert Administrator Address]

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President]

[SHORT TERM DISABILITY COVERAGE]

[**READ YOUR CERTIFICATE CAREFULLY**
You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.]

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

[**Table of Contents**

Schedule of Insurance

[The Policy of short term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You**.

The benefits described herein are those in effect as of DATE.

Cost of Coverage:
Option 1 - You do not contribute toward the cost of coverage under Option 1.

Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) For Coverage:
All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least # hours weekly

Weekly Benefit: The lesser of:
1) Option 1: X% of Your Pre-disability Earnings;
2) Option 2: X% of Your Pre-disability Earnings; or
3) $XX.

The Weekly Benefit will be rounded to the next higher $10.00/$1.00 if not already such a multiple.

Minimum Weekly Benefit: $XXX
In accordance with Arkansas state law, in no event will the Minimum Weekly Benefit be less than $12.50.

Maximum Duration of Benefits Payable:
1) if Your Disability is the result of a Pre-existing Condition: # days if caused by Injury or Sickness; otherwise
2) # weeks if caused by Injury or Sickness

Benefits Commence::
1) for Disability caused by Injury: on the 1st consecutive day of Total Disability or Disabled and Working;
2) for Disability caused by Sickness: on the 8th consecutive day of Total Disability or Disabled and Working
3) with the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program.

For hospital confinements of 24 hours or more, or for an Outpatient Surgical Procedure which necessitates a Total Disability period or a Disabled and Working Disability period of 24 hours or more after surgery, benefits commence:
1) on the first day of hospital confinement; or
2) on the date of the Outpatient Surgical Procedure.

Annual Enrollment Period: From month & day through month & day

Eligibility Waiting Period for Coverage
1) XX days - if You are Actively at Work for the Employer on the Policy Effective Date; or
2) XX days - if You start working for the Employer after the Policy Effective Date.

The number of days referenced above are continuous calendar days. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time/Part-time/temporary Active Employee with the Employer under the Prior Policy.]

Definitions

[Actively at Work means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for [Your usual number of hours.]

[We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.]

Active [Employee] means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.]

Any Occupation means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of:

1) [the product of Your Indexed Pre-disability Earnings and the Initial Benefit Period Percentage]; or
2) [the Maximum Weekly Benefit.]]

Bonuses means the [weekly average of monetary] bonuses You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]]

Commissions means the [weekly average of monetary] commissions You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]

[Current [Monthly/Weekly] Earnings means [Monthly/Weekly] earnings You receive from:

1) [the Employer; and
2) other employment;]

while You are Disabled [and eligible for the Disabled and Working Benefit.]

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly/Weekly] Earnings.]

[Current [Monthly/Weekly] Earnings also includes the pay You could have received for another job or a modified job if:

1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.]

Disabled and Working means that You [or Your Spouse] are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy]

from performing some, but not all of the Essential Duties of Your [or his or her] Occupation, are working on a part-time or limited duty basis [before age 70] [and, as a result, Your [or Your Spouse's] Current [Weekly] Earnings are more than [20]%, but are less than or equal to [80]% of Your [or Your Spouse's] Pre-disability Earnings.]

Disability or Disabled means Total Disability [or Disabled and Working Disability].

Employer means the [Policyholder].

Essential Duty means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.]

Injury means bodily injury resulting:

1) directly from accident; and
2) independently of all other causes;

[which occurs while You are covered under The Policy.] [However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.]

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

Mental Retardation;

1) Pervasive Developmental Disorders;
2) Motor Skills Disorder;
3) Substance-Related Disorders;
4) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
5) Narcolepsy and Sleep Disorders related to a General Medical Condition.

[Other Income Benefits means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuant to any:

1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the result of membership in or association with any group, association, union or other organization;
4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
6) [mandatory "no-fault" automobile insurance plan;]
7) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or
8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under the Employer's Retirement plan;
2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or
5) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
   d) similar plan or act;

   that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.]

Outpatient Surgical Procedure means a medically necessary surgical procedure performed by a Physician in the outpatient department of a hospital or ambulatory surgical center.

Participating [Employer] means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.]

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

[Pre-disability Earnings means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]:

1) the [weekly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for:
   a) the [X tax] year(s) just prior to the date of Disability; or
   b) the number of months You were employed in this capacity, if less than above period; and
2) [not] contributions You make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section125 plan,

   for the same period as above.

Pre-disability Earnings [does not include] [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital.

Pre-disability Earnings means, [for specific class description if applicable] Your average [weekly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period:

1) [not] including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense reimbursements for the same period as above.

Pre-disability Earnings means, [for specific class description if applicable], Your regular [weekly] rate of pay, including [Bonuses, Commissions and Tips and Tokens],

1) [not] including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions and tips and tokens] overtime pay or expense reimbursements for the same period as above.]

[Prior Policy means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitative Employment means employment or service which:

1) prepares a Disabled person to resume gainful work; and
2) is approved, in writing, by Us.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].]

[Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) [a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.]

Sickness means a Disability [or loss] which is:

1) caused or contributed to by:
   a) any condition, illness, disease or disorder of the body;
   b) any infection, except a pus-forming infection of an accidental cut or wound [or bacterial infection resulting from an accidental ingestion of a contaminated substance];
   c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or
   d) [pregnancy;]

caused or contributed to by any medical [or surgical] treatment for a condition shown in item 1) above.

Definitions

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

[Substance includes alcohol and drugs but excludes tobacco and caffeine.]

The Policy means the policy which We issued to [The Policyholder under the policy number] shown on the face page.

Tips [and Tokens] means the [weekly average of monetary] tips and tokens You received from [the Employer] [over:

1) the [X month] period ending [immediately prior to the date] You became Disabled; or
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]]

Total Disability or Totally Disabled means that You are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;]

from performing the Essential Duties of Your Occupation,[and as a result, You are earning 20% or less of Your Pre-Disability Earnings.]

Trust means [the trust fund established by XXX.]

We, Our, or Us means [the insurance company named on the face page of The Policy.]

[Weekly] Benefit means a [weekly] sum payable to You while You are Disabled, subject to the terms of The Policy. [Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.]

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

[If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.]

[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]

You or Your means the person to whom this certificate is issued.]

Eligibility and Enrollment

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:

1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage.

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]

Enrollment: *How do I enroll for coverage?*

[For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer.

For coverage under Option 2, You must enroll.] To enroll [for coverage]You must:

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:]

1) You must give Us Evidence of Insurability satisfactory to Us; and
2) [You may only enroll:
   a) during an [Annual Enrollment Period] designated by the Policyholder; or
   b) within [31 days] of the date You have a Change in Family Status.]

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability may include, but will not be limited to:

1) [a completed and signed application approved by Us;
2) a medical examination; and
3) any additional information and attending Physicians' statements.]

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

1) [You get married or You execute a domestic partner affidavit;
2) Your child is born or You adopt or become the legal guardian of a child;
3) Your spouse dies or You and Your spouse divorce;
4) Your child is emancipated or dies;
5) Your spouse is no longer employed, which results in a loss of group insurance; or
6) You have a change in classification from part-time to full-time or from full-time to part-time.]

Period of Coverage

Effective Date:
When does my coverage start?

[If You are not required to contribute toward The Policy's cost,] Your coverage will start:

1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or
2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.]

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:

1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then;
2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible;
3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or]
4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.]

Deferred Effective Date:
Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?

If You are absent from work due to:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;]

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day.

[Changes in Coverage: *Can I change my benefit option?*

[You may change Your benefit option only:

1) during an Annual Enrollment Period; or
2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

1) [the first day of the month following the Annual Enrollment Period;] or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:

1) the date You enroll for the change; or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.]]

Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:

1) the Deferred Effective Date provision; and

Pre-existing Conditions Limitations.]

Period of Coverage

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*

[If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Weekly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the [Weekly] Benefit which was paid by the Prior Policy; or
2) the [Weekly] Benefit provided by The Policy.]

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [weekly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination: *When will my coverage stop?*

Your coverage will end on the earliest of the following:

1) [the date] The Policy terminates;
2) [[the date] The Policy no longer insures Your class;]
3) [the date] premium payment is due but not paid by the Employer;
4) [the last day of the period for which You make any required premium contribution;]
5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;]
6) [the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason, unless coverage is extended under the Continuation Provisions; or
7) [the date Your Employer ceases to be a Participating Employer].

Period of Coverage

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium [by the Employer;] and
3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.]

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.]

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.]

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.]

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]]

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

[If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive [short term] Disability Benefits provided premiums for Your coverage continue to be paid.

After [short term] Disability benefit payments have ceased, Your insurance will be reinstated, provided:

1) You return to work for one full day as a [Full-time] Active Employee in an eligible class;
2) The Policy remains in force; and
3) the premiums for You were paid during Your Disability, and continue to be paid.]

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Benefits

Disability Benefit: *When do I qualify for Disability Benefits?*

If, while covered under this Benefit, You:

1) become Totally Disabled;
2) remain Totally Disabled; and
3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

[The amount of any Weekly Benefit payable will be reduced by:

1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
2) any income received from [the Employer] for the period You are Totally Disabled.]

[Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*

Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.]

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay [1/7] of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*

When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within [14] consecutive [calendar] days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [14] consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions [and Pre-existing Conditions Limitations] will apply to the new cause of Disability.

Termination of Benefit Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]]
4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
5) the date of Your death;
6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;]
7) [the last day benefits are payable according to the Maximum Duration of Benefits;
8) [the date Your Current Monthly/Weekly Earnings are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;] or
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;] or
10) [the date You refuse to participate in a Rehabilitation program, [or refuse to cooperate with or try:
    a) modifications made to the work site ro job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;]
    b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;]] or
11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
    a) You were receiving them prior to becoming Disabled; or
    b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [We will use the following calculation to determine Your [or Your Spouse's] [Weekly/Monthly] Benefit:

$$\text{[Weekly/Monthly] Benefit} = \frac{(A - B) \times C}{A}$$

Where
A = Your Pre-disability [Weekly/Monthly] Earnings.
B = Your Current [Weekly/Monthly] Earnings.
C = The [Weekly/Monthly Benefit] payable if You were Totally Disabled.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.]

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [the Weekly/Monthly Benefit] otherwise payable for Total Disability will be reduced by [%] of Your Current [Weekly/Monthly] Earnings. Your [Weekly/Monthly Benefit], however, will not be less [than the Minimum Weekly/Monthly Benefit.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.]

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [and payments under the Total Disability benefit under The Policy have begun, the following calculation will be used to determine Your [Weekly/Monthly Benefit]:

1) multiply Your Pre-Disability Earnings by the Benefit Percentage; and
2) compare the result with the Maximum Benefit; and
3) from the lesser amount deduct Other Income Benefits.

Current Weekly/Monthly Earnings will not be used to reduce Your [Weekly/Monthly] Benefit. However, if the sum of Your Weekly/Monthly Benefit and Your Current [Weekly/Monthly] Earnings exceeds [80% of] Your Pre-Disability Earnings, We will reduce Your [Weekly/Monthly] Benefit by the amount of the excess.]

If You are participating in a program of Rehabilitative Employment approved by us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence/Elimination Period.]

Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*

If, while You are Totally Disabled [or Disabled and Working], You accept Rehabilitative Employment, We will continue to pay a [Weekly/Monthly] Benefit.

The [Weekly/Monthly] Benefit We will pay will be equal to Your Total Disability [Weekly/Monthly] Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the [Weekly/Monthly] Benefit and total income received from Rehabilitative Employment may not exceed [100%] of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the [Weekly/Monthly] Benefit paid by Us will be reduced by the excess amount.

We reserve the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Policy.

If You remain Totally Disabled [or Disabled and Working] after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit [or Disabled and Working], subject to the Maximum Payment Period for such benefit.

OPTIONAL

Cost-Of-Living Adjustment:

How do my benefits keep pace with inflation?

We [will] adjust Your Weekly Benefit for increases in the cost-of-living if:

1) You have been Disabled for [12 consecutive months]; and
2) [You are receiving benefits;] [and
3) Your Current Weekly Earnings are less than or equal to 20% of Your Pre-disability Earnings;]

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.]

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

1) determining the lesser of:
   a) [%]; or
   b) [1/2] the percentage change in the Consumer Price Index;
2) multiplying the resulting percentage (%) times the Weekly Benefit for Disability being received; and
3) adding the resulting amount to Your Weekly Benefit.

You will not receive a Cost-of-Living Adjustment after:

1) You cease to be Disabled; [or
2) You have received [5] adjustments;] or
3) The Policy terminates.

When will the Cost-of-Living Adjustments end?

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered].

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

Benefits

Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:
The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.

Exclusions and Limitations

Exclusions: *What Disabilities are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused [or contributed to by] war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused [or contributed to by] an intentionally self-inflicted [Injury];
6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer;
7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for [365] consecutive day(s)] while insured under The Policy; or
2) [You have been continuously insured under The Policy for [365] consecutive day(s)].

Pre-existing Condition means:

1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the [730] day period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.]

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim.

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.]

Proof of Loss: *What is Proof of Loss?*

[Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current [Monthly/Weekly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.] All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits **if You refuse to be examined or meet to be interviewed by Our representative.**

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than [1 year] after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request.

Claim Payment: *When are benefit payments issued?*

When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as] Proof of Loss satisfactory to Us is received.

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid: *To whom will benefits for my claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to [$1,000] to a person who is Related to You and who, at Our sole discretion, is **entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.**

Claim Denial: *What notification will I receive if my claim is denied*

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

1) You must request a review upon written application within:
   a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

[Social Security: *When must I apply for Social Security Benefits?*

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We reserve the right to reduce Your [Monthly/Weekly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly/Weekly] Benefit by the estimated amount.

Your [Monthly/Weekly] Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly/Weekly] Benefit by an estimated amount and:

1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly/Weekly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly/Weekly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly/Weekly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision .

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) [retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.]

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.]

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) [You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate.]
2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly/Weekly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and

pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Reimbursement: *What are the Company's Reimbursement Rights?*

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

a) a legal judgment;
b) an arbitration award; or
c) a settlement or otherwise;

You must reimburse Us for the lesser of:

a) the amount of payment made or required to be made by Us; or

the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than [60 days] after the date proof of loss is given; or
2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud.

General Provisions

Misstatements:
What happens if facts are misstated?

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.]

Policy Interpretation:
Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

[Rider Language This rider forms a part of [The Policy to which it is attached] and [all] certificates given in connection with The Policy.

This rider becomes effective [on the later to occur of:

a) the effective date of the Policy or certificate to which this rider is attached; or
b) the first day of the month on or next following the date e accept Your application and required premium.]

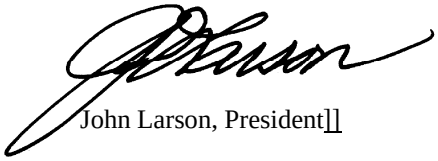
[In consideration of the required additional premium and submission of satisfactory evidence of insurability, the following 5 benefit is added to The Policy and certificates:]

In all other respects, The Policy and certificates remain the same.

Signed for **National Guardian Life Insurance Company**

[

[



Sherri Kliczak, Secretary John Larson, President]]

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
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TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 06/23/2008
Comments:
Attachments:
Reg 19 compliance certification_2008-06-18.pdf
AR readability certification_2008-06-18.pdf
NGL AR Notice.pdf

Satisfied -Name: Application
Review Status: Approved-Closed 06/23/2008
Comments:
Attachments:
Combined Master Application rev608.pdf
2006-NDN-VI-OTH Enroll - Enrollment Form rev308 _2_.pdf
PHI 3-08.pdf

Satisfied -Name: POI Forms List
Review Status: Approved-Closed 06/23/2008
Comments:
Attachment:
POI Forms List_2008-06-18.pdf

Satisfied -Name: Certificate Forms List
Review Status: Approved-Closed 06/23/2008
Comments:
Attachment:
AR DI Forms List_2008-06-18.pdf

Satisfied -Name: POI Statement of Variable Language
Review Status: Approved-Closed 06/23/2008
Comments:

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Attachments:

NGL POI_draft for SOVL_v3_2008-04-10.pdf

NGL_POI SOVL_v3_2008-04-10.pdf

SERFF Tracking Number:	*HARP-125623027*	*State:*	*Arkansas*
Filing Company:	*National Guardian Life Insurance Company*	*State Tracking Number:*	*39357*
Company Tracking Number:	*NGL001*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.005 Combined Short Term and Long Term*
Product Name:	*DI and POI*		
Project Name/Number:	*/*		

Satisfied -Name: LTD Statement of Variable Language

Review Status: Approved-Closed 06/23/2008

Comments:

Attachments:

NGL AR LTD Certificate_SOVL_2008-06-18.pdf

NGL AR LTD SOVL_2008-06-18.pdf

Satisfied -Name: STD Statement of Variable Language

Review Status: Approved-Closed 06/23/2008

Comments:

Attachments:

NGL AR STD Certificate_SOVL_2008-06-18.pdf

NGL AR STD SOVL_2008-06-18.pdf

Satisfied -Name: Guaranty Assoc. Notice

Review Status: Approved-Closed 06/23/2008

Comments:

Attachment:

Guaranty Notice _AR_.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: National Guardian Life Insurance company

Form Numbers: NHGRPOL et al
NHCRTLTD et al
NHCRTSTD et al
NVI/NDN Grp App 04/08
NDN/VI/OTH Enroll 04/08
PHI 0308

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Associate General Counsel
National Guardian Life Insurance Company

June 20, 2008

RE: National Guardian Life Insurance Company
Certification of Readability

To Whom It May Concern:

The following forms have been tested by an acceptable method specified in the Model Law and obtained Flesch scores as indicated:

1. Policy of Incorporation (NHGRPOL et al): 40.5
2. Group Long Term Disability Booklet Certificate (NHCRTLTD et al): 42.6
3. Group Short Term Disability Booklet Certificate (NHCRTSTD et al): 43.5

I hereby certify that the above application form complies with the N.A.I.C. Model Policy Language Simplification Act.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. Model.

Very truly yours,

Associate General Counsel

6/20/2008
Date

INSURER INFORMATION NOTICE

Any questions regarding The Policy may be directed to:

National Guardian Life Insurance Company
P.O. Box 98100
Baton Rouge, LA 70898

Phone: 888-729-5433
Fax: 888-729-7827

If the question is not resolved, the Arkansas Insurance Department may be contacted at:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street, Room 340
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

This notice is for information only and does not become a condition of The Policy.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

GROUP INSURANCE APPLICATION

Administered by: AlwaysCare

[Application is hereby made to National Guardian Life on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

Once approved, the application will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless written notice of a different effective date is sent.

If this application is not approved, no insurance is in effect at any time, and any deposit premium AlwaysCare has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): $ _____

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective.]

[Legal Name of Group_____

Physical Address _____

City\State\Zip _____

Billing Address (If different) _____

City\State\Zip _____

Federal Tax ID _____

Employees: _____ # Eligible: ____ # of Employees with Dependents: _____

Group Effective Date: _____ /_____ / _____]

[Contact for Administration & Eligibility:

_____

Phone: (_____)_____

Fax: (_____)_____

E-mail Address: _____]

[Contact for Billing _____

Phone: (_____)_____

Fax: (_____)_____

E-mail Address: _____]

Plan Selection:

[☐ **Dental Insurance** ☐ **Policy Year** ☐ **Calendar Year**

☐ **Vision Insurance**

☐ **Hearing Rider** (where applicable):

Attached to: ☐ Dental ☐ Vision

☐ **Basic Life (Employer Funded)**

☐ **Supplemental / Voluntary Life**

☐ **AD&D**

☐ **Dependent Life**

☐ **Short Term Disability**

☐ **Long Term Disability**

☐ **Other**_____ **]**

[Policyholder (Employer) contributions:]

[Dental	$_____	per month or ____ % of premium
Vision	$_____	per month or ____ % of premium
Basic Life and AD&D	$_____	per month or ____ % of premium
Supplemental / Voluntary Life and AD&D	$_____	per month or ____ % of premium
Short Term Disability	$_____	per month or ____ % of premium
Long Term Disability	$_____	per month or ____ % of premium]

[Eligibility: Permanent, full-time employees working 30 hours (Standard) or _____ (other) per week are eligible for coverage.
An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.
An eligible dependent must be less than ____ yrs. old or less than _____ yrs. old if a full-time student. Coverage becomes effective the first of the month following eligibility.

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):
☐ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
☐ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Participation: Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.

I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of full-time employees/members of this group. I will furnish with application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

Monthly Administration Fee: I understand there is a **$5.00** monthly administrative billing charge for groups with less than 10 employees enrolled.]

NVI/NDN Grp App 04/08

[IMPORTANT NOTES:
Unless agreed otherwise, membership cards, welcome letters and coverage summaries are printed and provided in a single package following group approval. The certificate of coverage, group policy, administration manuals and other information will be provided on a customized, group-specific CD-ROM to enable the Employer to distribute as needed via email or printouts to all enrolled employees. Employees may also print ID Cards and certificates by visiting our website at www.AlwaysCareBenefits.com.]

[Please send Membership Materials and Enrollment Materials to (CHECK ONE):
☐ Group Attn: _____Phone: (_____)_____
☐ Broker or Agent

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

The applicant understands that the requested group insurance will:

a. be issued only if the requested insurance is acceptable to National Guardian Life (the Company) and is legally permissible;
b. be issued under a group Policy or Policies in the language customarily used by the Company;
c. be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
d. be subject to all exclusions and limitations of the policy; and take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The applicant agrees not to:

a. collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
b. distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant Signature: _____ _____/_____/_____
Name Title Date

National Guardian Representative: _____ _____/_____/_____]
Date

[Agent (if applicable)	Tax I.D. Number
Firm Name (if applicable)	National Guardian Life Insurance Company appointment on file ☐Yes ☐ No **(Please attach Appointment Paperwork if not appointed)**
Address City/State/Zip	Phone Fax Email Address]

TO BE COMPLETED BY ALWAYSCARE BENEFITS

[Group Set Up Information
Group Code: _____
SIC Code: _____

Account Management Approval
Account Manager:_____
Signature_____ Date ____/____/_____]

Notes:

Administered by: AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by:[AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)]
[7800 Office Park Blvd., Baton Rouge, LA 70809-7603,(225)926-2888 or 1-888-729-5433]

EMPLOYEE INFORMATION **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

Employer Name	Group Number	Location	Effective Date

☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone

[COMPLETED BY EMPLOYER]

[Date of Hire]	[☐ Full time ☐ Part time If part time: Hrs worked per week: _____]	[Occupation]	[Class]

[Salary $: _____ ☐ Yearly ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly ☐ Hourly]

FAMILY INFORMATION (Only those eligible may be enrolled.) **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Unmarried child/ FT student/ handicapped? Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No

[BENEFIT ELECTIONS (Employer determines benefits available for election):]

[☐ **Dental**
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____]

[☐ **Vision**
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____]

[☐ **Basic Life / AD&D**
- Employee ☐ Elect ☐ Decline
- Spouse ☐ Elect ☐ Decline
- Children ☐ Elect ☐ Decline]

[☐ **Supplemental / Voluntary Term Life / AD&D**
- Employee ☐ Elect ☐ Decline $_____ or _____ X annual salary
- Spouse ☐ Elect ☐ Decline $_____
- Children ☐ Elect ☐ Decline $_____]

[☐ **Short Term Disability**
☐ Elect ☐ Decline
If Buy-Up Available: ☐ Elect ☐ Decline]

[☐ **Long Term Disability**
If Buy-Up Available: ☐ Elect ☐ Decline]

[Beneficiary Information (Complete ONLY for Life or AD&D):]

[Primary Beneficiary:	Relationship:	Date of Birth:
Contingent Beneficiary:		]

In the past 12 months, have you had continuous group coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no
If yes, please provide: Policyholder _____ and Insurance Company _____
Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage
☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements on page 2 and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from National Guardian Life Insurance Company.

Your signature X_____ Date signed _____

Administered by:
AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by:[AlwaysCare Benefits, Inc. (A Starmount Life Insurance Company)]
[7800 Office Park Blvd., Baton Rouge, LA 70809-7603,(225)926-2888 or 1-888-729-5433]

[I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. If I refuse [dental or vision] coverage, I and/or my dependents may enroll later [but this will affect the level of benefits]. [If I refuse life and/or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by National Guardian Life Insurance Company]. If I refuse coverage, I cannot enroll after retirement.]
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage. I agree National Guardian Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I authorize National Guardian Life Insurance Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by National Guardian Life for claims administration [and determining eligibility for life and disability coverage]. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by National Guardian Life Insurance Company only as allowed by law.]
- [NOTE For Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.]
- [For Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.]

A copy of this form will be as valid as the original.

After this form is completed and signed, make two copies and send the original to:

National Guardian Life Company
c/o AlwaysCare Benefits
P.O. Box 98100
Baton Rouge, LA 70898-9100

• Employer – copy of Page 1 and Page 2

• Employee – copy of Page 1 and Page 2

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Administered by: AlwaysCare

PERSONAL HEALTH INFORMATION

Thank you for choosing AlwaysCare Benefits, Inc. (a Starmount Life Insurance Company) and National Guardian Life Insurance Company. All sections of this form must be completed and received by AlwaysCare within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with National Guardian Life or AlwaysCare. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1 –Employer Details *(to be completed by Employer)*	**PLEASE PRINT CLEARLY**
Employer Name:	Policy Number:
Division *(if applicable):*	
Employer Mailing Address (Street, City, State, Zip Code):	
Benefits Contact Name: (First, Last)	
Benefits Contact Email Address:	Benefits Contact Phone: ( ) -

Section 2 – Applicant Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name: (First, MI, Last)

Base Annual Earnings*:	Social Security Number: - -	Date of Hire (mm/dd/yyyy): / /

* Base annual earnings as described in the contract with National Guardian Life Insurance Company.

Coverage Details

- Check the box(es) next to each row of the applicant's existing or new employer-sponsored coverage.
- Enter the amount of any **existing** coverage (including Guarantee Issue*) in **Current Coverage**. Please include the amount of Employee Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** by the applicant that requires Medical Underwriting.
- If the applicant is enrolling after his/her initial eligibility, check **Late Entrant** as the **Reason for Medical Underwriting**, if not, check **Other** as the reason.

		Reason for Medical Underwriting	**Current Coverage**	**Additional Coverage Requested**
		Enter all amounts as dollars or as percentages of Base Annual Earnings		
	Life Insurance Coverage			
☐	Employee Basic Life	☐ Late Entrant ☐ Other		
☐	Employee Supplemental or Voluntary Life	☐ Late Entrant ☐ Other		
☐	Spouse Basic Life	☐ Late Entrant ☐ Other		
☐	Spouse Supplemental or Voluntary Life	☐ Late Entrant ☐ Other		
	Disability Insurance Coverage			
☐	Short-Term Disability	☐ Late Entrant ☐ Other		
☐	Long Term Disability	☐ Late Entrant ☐ Other		

* Guarantee Issue is the maximum amount of coverage – as defined in the contract with National Guardian Life Insurance Company – that does not require an applicant to provide proof of good health.

Is the employee requesting more than $15,000 of coverage for a child? ☐**Yes** ☐ **No**	Number of Children:	Amount Requested Per Child: $

Employees: Please complete pages two and three.
It should take you about 7 to 10 minutes to complete this form

Employee: First Name_____ **Last Name**_____

Employee Section

Please answer all questions on this page completely and accurately and certify your answers on the next page. **Leaving information blank will result in delays and may result in your file being closed.** AlwaysCare may contact you for additional or missing information.

Section 3 – Employee Information *(Complete even if employee is not applying for coverage)* **PLEASE PRINT CLEARLY**

Home Mailing Address (Street, Apt. #):		City:	
State:	Zip Code:	Employer:	
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In.	Weight_____ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:	

Section 4 –Spouse or Eligible Partner Information *(Complete only if applying for this coverage)* **PLEASE PRINT CLEARLY**

First Name:	Last Name:	Social Security Number - -	
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In.	Weight_____ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:	

Section 5 – Medical Information *(to be completed only by applicants requesting coverage)*

If you or anyone proposed for coverage can answer *Yes* to any of Questions 1 – 6 below, check the appropriate box and provide **additional details in Section 6. Residents of Florida, Maine, Minnesota, North Carolina, Vermont or Wisconsin, please review the condition specific wording required by your state on page 4 of this form prior to answering these questions.**

1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	☐ Employee	☐ Spouse
2. Within the past 2 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	☐ Employee	☐ Spouse
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	☐ Employee	☐ Spouse
4. Are you currently pregnant? _____ If yes, what was your pre-pregnancy weight?_____ lbs	☐ Employee	☐ Spouse
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immune deficiency disorder?	☐ Employee	☐ Spouse

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below?

	Employee	Spouse		Employee	Spouse
Heart Related Surgery or Heart Attack	☐	☐	Crohn's Disease	☐	☐
Stroke	☐	☐	Kidney Failure/Dialysis	☐	☐
Heart Disease (excluding high blood pressure & heart murmur)	☐	☐	Hepatitis (excluding Hepatitis A)	☐	☐
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysms, or deep vein blood clots)	☐	☐	Diabetes	☐	☐
Chronic Obstructive Pulmonary Disorder (COPD)	☐	☐	Knee Disorder, Injury, or Surgery	☐	☐
Emphysema	☐	☐	Back or Neck Disorder, Injury, or Surgery	☐	☐
Adjustment Disorder	☐	☐	Joint/Ligament Disorder, Injury, or Surgery	☐	☐
Bipolar Disorder	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression (single episode)	☐	☐	Multiple Sclerosis (MS)	☐	☐
Depression (multiple episodes)	☐	☐	Amyotrophic Lateral Sclerosis (ALS)	☐	☐
Psychotic/Personality Disorders	☐	☐	Muscular Dystrophy	☐	☐
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	☐	☐	Arthritis	☐	☐
Cancer (excluding Basal Cell Carcinoma)	☐	☐	Fibromyalgia	☐	☐
Cirrhosis	☐	☐	Chronic Fatigue Syndrome	☐	☐
Ulcerative Colitis	☐	☐	Sleep Apnea	☐	☐

Employee First Name_____ **Last Name:** _____

Section 6 – Additional Details: If you or anyone proposed for coverage checked any box next to Questions 1 – 6, please provide details in the space below. If you need more space, please attach, sign and date an additional sheet.

Question # or Condition	Applicant Name	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name and Phone #

Section 7 – Certification Statement *(To be completed by all applicants)*

By checking this box: ☐ **Employee** ☐ **Spouse**

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 8 – Fraud Statement *(To be completed by all applicants)*

I hereby certify that the above statement and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statement and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This information may be used by AlwaysCare (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage. I acknowledge that I have read the disclosure notice on the last page of this application.

Notice: *Anyone applying for coverage is required to notify National Guardian Life and AlwaysCare in writing at the address below of any changes in their medical condition to the best of their knowledge between the date you sign this form and the date the coverage is approved.*

_____ ____/____/____ _____ ____/____/____

Employee's Signature or Legal Representative/ Relationship to Employee **(Required)** — **Date Signed**

Spouse's (or Eligible Partner's) Signature or Legal Representative/Relationship to Spouse **(Required only if applying for coverage)** — **Date Signed**

Please return the completed Employer and Employee sections to:
National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc.
P.O. 98100
Baton Rouge, LA 70898-9100

If you have any questions or concerns about this form, please call AlwaysCare's Customer Service Department toll-free at 888-729-5433, Ext. 2013, Monday through Friday, 7:30 a.m. – 8:30 p.m. (CST), Saturday, 9:00 a.m. – 3:00 p.m. (CST)**.**

State Specific Information
Please Do Not Return This Page – Retain for Your Records

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTON, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

Florida residents: AIDS/HIV Condition: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Maine residents: You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota residents: YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE: (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

North Carolina residents: AIDS/HIV Condition: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont residents: AIDS/HIV Condition: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Wisconsin residents: AIDS/HIV Condition: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Disclosure Notice
Please Do Not Return This Page – Retain for Your Records

I authorize AlwaysCare Benefits (a Starmount Life Insurance company) and National Guardian Life Insurance Company to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organization, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I understand that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, AlwaysCare and National Guardian Life must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the authorization on the application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: AlwaysCare Benefits, Inc., Privacy Officer, P.O. Box 98100, Baton Rouge, LA 70898-9100.

All policies are underwritten by National Guardian Life Insurance Company*.

*National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian or Guardian Life.

LIST OF FORMS	
POLICY OF INCORPORATION	
Form Number	Description
NHGRPOL 4/08	Base Form Number Policy Face Page
NHGRPOL-SCH 4/08	Schedule of Insurance
NHGRPOL-PX 4/08	Premium Provisions
NHGRPOL-PXSch 4/08	Premium Schedule
NHGRPOL-Par 4/08	Participating Entities
NHGRPOL-Prov 4/08	Policy Provisions
NHGRPOL-Inc 4/08	Incorporation Provision
NHGRPOL-RID 4/08	Policy Modifications
RELATED FORMS	
NVI/NDN Grp App 04/08	Master Application
NDN/VI/OTH Enroll 04/08	Enrollment Form
PHI 0308	Personal Health Statement

ARKANSAS
LIST OF FORMS

LONG TERM DISABILITY CERTIFICATE

Form Number	Description
NHCRTLTD 4/08	Base Form Number Certificate Face Page
NHCRTLTD-SCH (AR) 4/08	Schedule of Insurance
NHCRTLTD-DEF 4/08	Definitions
NHCRTLTD-E&E 4/08	Eligibility and Enrollment
NHCRTLTD-PoC 4/08	Period of Coverage
NHCRTLTD-BEN 4/08	Benefits
NHCRTLTD-BEN-Term 4/08	Termination of Payment
NHCRTLTD-BEN-FC/Cola 4/08	Family Care Credit Cost-of-Living Adjustment
NHCRTLTD-BEN-SurvInc 4/08	Survivor Income Benefit
NHCRTLTD-BEN-ExtErn/Wrk 4/08	Extended Earnings Protection Benefit Workplace Modification Benefit
NHCRTLTD-BEN-PC/ICD 4/08	Pension Contribution Benefit Infectious and Contagious Disease Benefit
NHCRTLTD-BEN-ADL 4/08	Activities of Daily Living Benefit
NHCRTLTD-BEN-AD 4/08	Accidental Dismemberment and Loss of Sight Benefit
NHCRTLTD-BEN-BsProt 4/08	Business Protection Benefit
NHCRTLTD-EXCL 4/08	Exclusions and Limitations
NHCRTLTD-Prov 4/08	General Provisions
NHCRTLTD-RID 4/08	Rider Language

SHORT TERM DISABILITY CERTIFICATE	
Form Number	Description
NHCRTSTD 4/08	Base Form Number Certificate Face Page
NHCRTSTD-SCH (AR) 4/08	Schedule of Insurance
NHCRTSTD-DEF 4/08	Definitions
NHCRTSTD-E&E 4/08	Eligibility and Enrollment
NHCRTSTD-PoC 4/08	Period of Coverage
NHCRTSTD-BEN 4/08	Benefits
NHCRTSTD-BEN-Rehab 4/08	Rehabilitative Employment Benefit
NHCRTSTD-BEN-Cola 4/08	Cost-of-Living Adjustment
NHCRTSTD-Caf 4/08	Cafeteria Plan Election Restriction
NHCRTSTD-EXCL 4/08	Exclusions and Limitations
NHCRTSTD-Prov 4/08	General Provisions
NHCRTSTD-RID 4/08	Rider Language

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

Name of Policyholder: [ABC POLICYHOLDER**]** **1**

Policy Number:
[XXXXXX**]**

Effective Date:
[January 1, 2004**]**

Place of Delivery:
[ANY STATE**]**

Anniversary Dates:
[January 1 of each year beginning in 2005**]**

Premium Due Dates:
[Monthly, on the first day of each policy month]

Administrator: [Insert Administrator Name
Insert Administrator Address] **2**

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
will pay benefits according to the terms and conditions of The Policy.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President] **3**

[TEN DAY RIGHT TO EXAMINE POLICY

The Company urges you to examine this policy closely. If you are not satisfied with it, you may send it back to The Company for any reason within 10 days after the date you receive it. If so returned, your insurance will be canceled, and any premium paid will be refunded in full.] **4**

:

Countersigned by.....……..
[Licensed Resident Agent or] Registrar **5**

Table of Contents

6

Schedule of Insurance

The Schedule(s) of Insurance for The Policy benefits listed below are shown in the Certificate(s), as incorporated into The Policy. **1**

1) [Basic Life Insurance
2) Supplemental Life Insurance
3) Accidental Death, Dismemberment and Loss of Sight Benefit
4) Supplemental Accidental Death, Dismemberment and Loss of Sight Benefit
5) Dependent Life Insurance
6) Spouse Accidental Death, Dismemberment and Loss of Sight Benefit
7) Short Term Disability Insurance
8) Long Term Disability Insurance
9) Supplemental Spouse Accidental Death Dismemberment and Loss of Sight Benefit]

The Schedule(s) of Insurance will control the:

1) [benefit amounts and maximum limits; **2**
2) eligibility and effective date requirements; and
3) other schedule amounts and limits;

which apply to the employees of the Policyholder.]

Premium Provisions

Initial Monthly Premium Rates

The initial monthly premium rates to be charged [for employee Coverage and/or child/spouse coverage, if applicable, are shown on the following page(s).] **1**

The first premium is due and payable on the effective date of The Policy. Subject to The Policy's grace period provision, all premiums after the first must be paid when or before they are due.

[Premiums are based on the Employee's: **2**

1) age on his or her effective date and thereafter on the first day of the month following the month in which his or her birthday occurs;]
2) [sex and occupational class.] **3**

[For Long Term Disability Benefits, the amount of an employee's Earnings which is disregarded in determining his Monthly Benefit because of the Maximum Monthly Benefit limitation will also be disregarded in determining the amount of the total insured payroll.] **4**

The Initial Monthly Premium Rates may be converted as follows:

To Convert Rates to:	**Use a Conversion Factor of:**
-- annual rates	11.8227
-- semi-annual rates	5.9557
-- quarterly rates	2.9852

Grace Period

The Company will allow the Policyholder a [31] day grace period for the payment of all premiums after the first. During this [31] day period, The Policy will stay in force. If the owed premium is not paid by the [31st] day, The Policy will automatically terminate. If the Policyholder gives The Company written advance notice of an earlier cancellation date, The Policy will terminate on the earlier date. Premium is due for each day The Policy is in force. **5**

[Monthly Premium Rate Guarantee **6**

Initial Monthly Premium rates are guaranteed as follows:

Benefit	**Rate Guarantee Period**
[Basic Life Insurance	6 months
Basic Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Life Insurance	6 months
Supplemental Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Dependent Life Insurance	6 months
Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Supplemental Spouse Accidental Death, Dismemberment and Loss of Sight Insurance	6 months
Long Short Term Disability Benefits Term Disability Benefits	6 months]

[Subject to the Rate Guarantee period shown above, The Company has the right to change premium rates on any premium due date if: **7**

1) written notice is delivered to the Policyholder's last address on record; and
2) the change is effective at least [31] days after the date of notice.] **8**

[The Rate Guarantee supersedes only those provisions appearing elsewhere in this policy which give The Company the right to change the premium rates, and then, only for the period of time for which the rates are guaranteed. However, The Company may change the premium rates during the Rate Guarantee period if there is a [10%] change in The Policy, or if there is an increase or decrease in the number of insured employees, or if the Policyholder adds or deletes a subsidiary or affiliated business entity. The Company may also change the premium rates during the Guarantee Period if there has been a material misstatement in the reported experience during the pre-sale process. The Rate Guarantee in no way affects, amends or supersedes any other provision in The Policy.] **9** **10**

Premium Provisions

Calculation
Premiums may be calculated by multiplying the rate times the applicable number of units of coverage.

If any insurance is added, increased or becomes effective after The Policy is in force, the premium charges will begin on:

1) the day the coverage is effective, if it is also the first day of a policy month; or
2) the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month. [With respect to **1** Dependent Life Insurance only, the premium rate per Dependent Unit or per $1,000 of insurance, whichever is applicable, will be based on actuarial assumptions, due to the difficulty in obtaining the ages of all Dependents who are covered under this benefit. The actuarial assumptions will produce, in the opinion of The Company, the same total amount of premium as would be obtained by the use of the actual ages of the Dependents covered.]

Premiums may be calculated by any other method which both The Company and the Policyholder agree to in writing.

Premium Payments
Premium payments are due and payable in full to a place designated by The Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of The Company. Payment of premiums for a period before it is due will not guarantee the insurance for that period.

[Experience Rating **2**
If The Policy is experience rated, any credit amount due the Policyholder will be allowed on The Policy Anniversary Date and, at the Policyholder's request, will be:

1) paid to the Policyholder in cash;
2) used to reduce the Policyholder premiums; or
3) used to provide additional insurance for Covered Persons.

Any credit amount shall be determined by the rating plan or plans used by The Company.]

[Combined Experience **3**
If the experience of The Policy is combined with other policies, it shall be combined only with the experience of the following Policies: XXXXX; XXXXX and XXXXX]

PREMIUM SCHEDULE

[Long Term Disability: PREMIUMS
Short Term Disability: PREMIUMS
Life Insurance: PREMIUMS
Accidental Death and Dismemberment: PREMIUMS]

Participating [Entities]

The Policyholder means [ABC Policyholder.] **1**

Participating [Entity] means any [Entity] that has [become a member of ABC Policyholder.]

The Company or The Policyholder, by written request, may add to or delete from the list of Participating [Entities] in The Policy [at any time.] [The Company will keep a list of Participating [Employers] accepted by The Company and the effective dates of coverage for each.] **2, 3**

Any change, subject to The Company's written approval, will become effective [on a date which is mutually agreeable to the Policyholder and The Company.] The Policyholder may act for or on behalf of all Participating [Entities] in all matters of The Policy. The following will be binding on all Participating [Entities]: **4**

1) all agreements between The Company and the Policyholder;
2) all notices from The Company to the Policyholder; and
3) all notices from the Policyholder to The Company.

Each reference in the Policy to a relationship between the Policyholder and its Eligible Persons includes the same relationship between each Participating [Entity] and its [Eligible Persons], except where the Policy describes specific differences. **5**

Individual Effective Date: A person associated with a Participating [Entity] will not:

1) become an Eligible Person before the [Entity] qualifies; or
2) continue as an Eligible Person after the [Entity] ceases to qualify;

as a Participating [Entity].

Premiums: A Participating [Entity]'s premiums will be calculated based on:[

1) the coverage requested; and
2) the data given to The Company by the Participating [Entity].]

[Data Given by Participating [Entity]: The Participating [Entity], with our approval, may keep the important insurance records on all persons covered under The Policy. The Participating [Entity] or its designee must give The Company information, when and in the manner The Company asks, to administer the insurance provided by the Policy. **6**

[The Participating [Entity] will, upon our request, give us: **7**

1) the names of all persons initially eligible for coverage;
2) the names of all additional persons who become eligible for coverage;
3) the names of all persons whose amount of insurance is to be changed;
4) the names of all persons whose eligibility or insurance is terminated; and
5) any data necessary to administer the insurance provided by the Policy.]

The Participating [Entity]'s failure to:

1) give The Company the name of any person covered under The Policy will not invalidate such person's insurance;
2) [report a person's termination of insurance will not continue the coverage beyond the date of termination.] **8**

The Policyholder's and/or Participating [Entity]'s insurance records will be open for our inspection at any reasonable time.

Upon termination of coverage, any unearned premium will be calculated on a pro-rata basis. The Company will promptly return any unearned premium paid.]

Participating [Entity] Termination Date: A Participating [Entity] will cease to be covered on the first to occur of:

1) [the date the Participating [Entity] ceases to be a member of the Policyholder; **9**
2) the date requested by the Participating [Entity] but not prior to The Company's receipt of the request;
3) the date the Participating [Entity] fails to maintain the applicable participation requirements;
4) the termination date of the Policy;
5) the date the Participating [Entity's] premium is due, but not paid; or
6) the date on which the Policyholder requests that the [Entity] be removed from The Policy. Such date must be stated in a written notice to The Company, and must be after the date of the notice.

Participating [Entities]

[**Name of Participating [Entity]**	**Effective Date**	**Account Number**	**Termination Date**	
ABC [Entity]	January 1, 2004	000-00-0000	]	**1**

]

Policy Provisions

Entire Contract:
The contract between the parties consists of:

1) the Policy;
2) any certificates incorporated and made a part of the Policy;
3) any riders issued in connection with such certificates;
4) the Policyholder's application, if any, a copy of which is attached to and made a part of The Policy when issued; and
5) any Written Medical Insurability Application submitted by the Eligible Person/Employee and accepted by The Company in connection with the Policy.

All statements made by the Policyholder, Participating [Entity] or persons insured under The Policy will be deemed representations and not warranties. No statement made to effect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary. **1**

Incontestability:
Except for non-payment of premium, the insurance provided by The Policy cannot be contested after such insurance has been in effect for a period of [2 years.] **2**

Changes: The Company reserves the right to make changes in the Policy, [after The Policy has been in force for 12 months.] The Company will give the Policyholder [31 days] advance written notice of any change. No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, approved by one of our officers and made a part of the Policy. **3** **4**

[**30 Day Right to Examine Certificate:** The Insured Person has a [30 day] right to examine his or her Certificate. If the [Insured Person] is not satisfied, he or she may return it to The Company within [30 days] of his or her effective date. In that event, The Company will consider it void from the certificate effective date and any premium paid will be refunded. Any claims paid under the Policy during the initial [30 day] period will be deducted from the refund.] **5,6**

Clerical Error: Clerical error (whether by the Policyholder, the Plan Administrator, or us) in keeping the records having to do with the Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. A clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by the Policy. When a clerical error is found, premiums and benefits will be adjusted based on the true facts and the Policy.

Conformity with Law: If any provision of the Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law, including but not limited to the Federal Social Security Act, affects The Company's liability under The Policy, The Company may change The Policy, the premiums or both. Such change:

1) will be effective as of the date of the change to the state or federal law; and
2) will not be made until The Company gives the Policyholder [31 days] notice**.** **7**

[Termination of Policy
The Company may terminate The Policy for the following reasons by giving the Policyholder [31] days written notice: **8,9**

1) The Policyholder fails to furnish any information which The Company may reasonably require;
2) The Policyholder fails to perform any of his other obligations pertaining to this policy;
3) [Less than 100% of the persons eligible for coverage on a Non-contributory Basis are insured; or] **10**
4) [Less than 75% of the persons eligible for coverage on a Contributory Basis are insured.] **11**
5) [Fewer than 10 persons are insured.] **12**

In addition, The Company may terminate this policy on any premium due date after The Policy has been in force for [12 months] **13**
by providing [31 days] written notice. **14**

The Company reserves the right to terminate Dependent Life Insurance Benefits on any premium due date on which:

1) [there are fewer than 10 persons insured for Dependent Coverage; or] **15**
2) [less than 75% of the persons eligible for Dependent Coverage on a Contributory Basis are insured.] **16**

The Company shall give the Policyholder [31 days] notice of its intent to terminate the Dependent Life Insurance Benefit.] **17**

Policy Provisions

[**Cancellation:** The Policy may be cancelled [at any time] by written notice mailed or delivered by The Company to the Policyholder, or by the Policyholder to us. If The Company cancels, The Company will mail or deliver the notice to the Policyholder at its last address shown in our records. If The Company cancels, it becomes effective [on the later of: **1, 2** **3**

1) the date stated in the notice; or
2) the 31st day after The Company mails or delivers the notice.]

If the Policyholder cancels, it becomes effective [on the later of: **4**

1) the date The Company receives the notice; or
2) the date stated in the notice.]

In either event:

1) The Company will promptly return to the Policyholder any unearned premium; or
2) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis. Cancellation will be without prejudice to any claim which commenced prior to the effective date of the cancellation.]

Certificates: The Company will give individual certificates to:

1) the Policyholder; or
2) any other person according to a mutual agreement among the other person, the Policyholder, and us;

for delivery to persons covered under The Policy and which will explain the important features of The Policy.

Data To Be Furnished

The Policyholder, or any other person designated by the Policyholder, will give The Company all information The Company needs regarding matters pertaining to the insurance. At any reasonable time while The Policy is in force and for [12 months] after that, **5** The Company may inspect any of the Policyholder's documents, books, or records which may affect the insurance or premiums of this policy.

The Policyholder will, upon our request, give us: **6**

1) [the names of all persons initially eligible for coverage;
2) the names of all additional persons who become eligible for coverage;
3) the names of all persons whose amount of insurance is to be changed;
4) the names of all persons whose eligibility or insurance is terminated; and
5) any data necessary to administer the insurance provided by the Policy.]

If the Policyholder gives The Company any incorrect information, the relevant facts will be determined to establish if insurance is in effect and in what amount.

No person will be deprived of insurance to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the Policyholder. Any required adjustment may be made in premiums or benefits.

Right to Audit: The Company reserves the right to audit, [once every 2 years,] the Policyholder's billing records and premium accounting practices. If The Company discovers: **7**

1) an underpayment of premium by the Policyholder, the Policyholder will be obligated to remit, in a timely manner, the underpayment amount; or
2) an overpayment of premium, The Company will return any overpayment amount in a timely manner;

for the previous [2 year period.] **8**

[Dividends: As long as a Certificate is in force, the Certificate owner will receive the dividends We declare, if any, in cash annually.] **9**

[Right to Vote: The Company is a mutual company. The Policyholder may vote at the annual election of directors if the Policyholder has one or more policies issued by The Company in force. The annual election is held at Our Home Office in Madison, Wisconsin, on the fourth (4^{th}) Friday in April.] **10**

[**Not in Lieu of Worker's Compensation:** This Policy does not satisfy any requirement for worker's compensation insurance.] **11**

Time Period

All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Incorporation Provision

The Certificate(s) of Insurance [and Riders and Policy Changes] listed below are attached to, incorporated in and made a part of, this Policy.

[Certificate of Insurance	Applicable to:	Effective Date of Incorporation	Termination Date
XXXX	All Eligible Persons	January 1, 2004	January 1. 2005

Rider	Applicable to:	Effective Date of Incorporation	Termination Date
XXXX	All Eligible Persons	January 1, 2004	January 1. 2005

Policy Changes	Applicable to:	Effective Date of Change	Termination Date
Policy Page Added: XXX	All Eligible Persons	January 1. 2004	January 1, 2005
Policy Page Deleted: XXX	All Eligible Persons	January 1. 2004	]

The provisions found in the Certificate will control the benefit plan, period of coverage, exclusions, claims and other general policy provisions pertaining to state insurance law requirements.

Policy Modifications

[**Policy Modifications:** The Policy is amended as follows:

The initial monthly premium rates for Class 3 will be $ for each $1,000 of Basic Life Insurance and $ for each $1,000 of Supplemental Life Insurance.

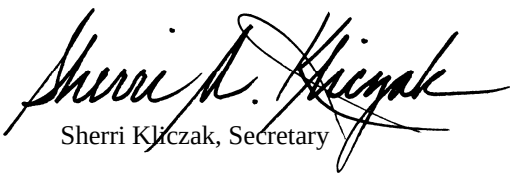
The Rate Guarantee Period for Class 3 will be:

Basic Life Insurance	3 months
Supplemental Life Insurance	3 months

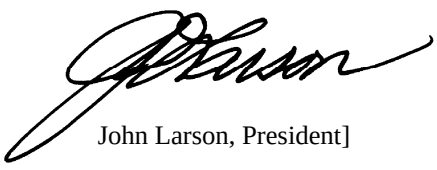
In all other respects, The Policy remains the same.

[RIDER: This rider, issued [January 1, 2004], forms a part of Policy No. [XXXX] issued to [**Policyholder**]. It is effective [June 1, 2004]. It does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for **The Company [**



Sherri Kliczak, Secretary



John Larson, President]

Statement of Variable Language

Group Policy of Incorporation

NHGRPOL 4/08 et al

Introduction: This statement of variable material (SOVL) shows the language we intend to substitute, delete or change. Variable language is identified by brackets ([ ]) in each module of Form(s) NHGRPOL 4/08 et al. Each module is identified in this SOVL and each variable within each module is numbered on the form. These numbers directly correspond with the numbers on the SOVL for the appropriate module.

Constant Variables

1	Wherever the term "the Employer" appears, it may be changed to "Your employer" or some other term to accommodate non-Employer groups
2	Wherever the term "Employee" appears, it may be changed to "Member" or "Associate" or some other term, to reflect the case specifics
3	Wherever the term "Policyholder" appears, it may be changed to "Employer" or "Organization" or some other term to reflect the case specifics

Form #	Description	Variable #	Description of Variables
NHGRPOL 4/08	Policy Face page	1	Fill-in information will vary by Policyholder; fill-in items may be deleted in whole or in part.
		2	Included when administrator involved; fill-in information will vary dependent on the specific administrator
		3	signatures will change if officers change
		4	may be in or out; 10 days may be 30, 45, 60, 90 or 180
		5	table of contents may be expanded and detailed and may appear on next page or a separate page
		6	"Licensed Resident Agent" may be deleted if not required by statute
NHGRPOL-SCH 4/08	Schedule of Insurance	1	list of benefits will be amended to meet specifics of the case
		2	items in list may be deleted or added to to meet specifics of the case; reference to employees may be changed to members or some other term to reflect the case specifics
NHGRPOL-PX 4/08	Premium Provisions	1	reference to "child/spouse coverage, if applicable," may be deleted
		2	entire paragraph is optional language - used if premiums are based on age of Employee; "birthday language" may be replaced by "on each January 1st thereafter" or "on eac h Policy Anniversary date thereafter" to meet case specifics
		3	may be deleted or one or the other item may be deleted to meet case specifics
		4	paragraph will be deleted if no LTD sold
		5	references to 31 days may be 31 to 90 days
		6	provision may be in or out; 6 months may be 6-36 months; benefit references will be amended to reflect case specifics
		7	paragraph will be deleted if no rate guarantee provision included
		8	31 may be 60 to 90
		9	paragraph will be deleted if no rate guarantee provision included
		10	10% may be 10-25%
	Premium Provisions	1	may be deleted
		2	may be deleted
		3	may be deleted; if used, actual Policy numbers will be shown
NGRPINC-PXSch 4/08	Premium Schedule		information on page is illustrative
NHGRPOL-Par 4/08	Participating [Entities]	1	wherever "Entities/Entity" is used, may be: organization, firm, employer or some other description of participating entity
		2	may be: on January 1 of each year or some other recurring date
		3	may be deleted
		4	may be: on January 1 of each year or some other recurring date
		5	may be Employee
		6	entire provision may be deleted
		7	any or all items may be deleted or amended to meet case specifics
		8	may be deleted
		9	any item in list may be deleted to meet case specifics

Form #	Description	Variable #	Description of Variables
	Participating [Entities]	1	wherever "Entities/Entity" is used, may be: organization, firm, employer or some other description of participating entity; other language is illustrative
NHGRPOL-Prov 4/08	Policy Provisions	1	wherever "Entities/Entity" is used, may be: organization, firm, employer or some other description of participating entity
		2	may be 2-5 years
		3	may be 6-36 months
		4	may be 31-90 days
		5	may be deleted
		6	each reference to 30 may be 30-180 days
		7	may be 31-90 days
		8	may be deleted
		9	may be 31-90 days
		10	may be 10-100% or may be deleted
		11	may be 10-100% or may be deleted
		12	may be 10-200 or may be deleted
		13	may be 6-36 months
		14	may be 31-90 days
		15	may be 10-200 or may be deleted
		16	may be 25-85% or may be deleted
		17	may be 31-90 days
	Policy Provisions	1	may be deleted
		2	may be "after the first Policy Anniversary Date"
		3	actual date may be stated or 31 may be 31-90 days
		4	actual date may be stated
		5	may be 12-36 months
		6	any or all items may be deleted or amended to meet case specifics
		7	may be once each year or 2-5 years
		8	may be once each year or 2-5 years
		9	may be deleted
		10	meeting date may be changed; provision may be deleted
		11	may be deleted
NHGRPOL-Inc 4/08	Incorporation provision		information on page is illustrative

INSURER INFORMATION NOTICE

Any questions regarding The Policy may be directed to:

National Guardian Life Insurance Company
P.O. Box 98100
Baton Rouge, LA 70898

Phone: 888-729-5433
Fax: 888-729-7827

If the question is not resolved, the Arkansas Insurance Department may be contacted at:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street, Room 340
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

This notice is for information only and does not become a condition of The Policy.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

CERTIFICATE OF INSURANCE

[Policyholder: ABC Policyholder] **1**
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE] **[Participating Entity]**
[Policy Anniversary Date: DATE] **[Account Number: XXXXXXX]**

Administrator: [Insert Administrator Name
Insert Administrator Address] **2**

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President] **3**

[LONG TERM DISABILITY COVERAGE] **4**

[**READ YOUR CERTIFICATE CAREFULLY**

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.] **5**

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

6

[**Table of Contents**

Schedule of Insurance

[The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You**. **1**

The benefits described herein are those in effect as of DATE.

Cost of coverage:
Option 1 - You do not contribute toward the cost of coverage under Option 1.
Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) for Coverage: All Full-time and Part-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment:	at least # hours weekly
Part-time Employment:	at least # hours weekly, but less than # hours weekly

Annual Enrollment Period: MONTH & DAY through MONTH & DAY.

Maximum Monthly Benefit: $XXXXXXX

Guaranteed Issue Amount: $XXXXXXX

Minimum Monthly Benefit: the greater of:
1) $ # ; or
2) # % of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

In accordance with Arkansas state law, in no event will the Minimum Monthly Benefit be less than $50.

Initial Benefit Period Percentage:
Option 1: #%
Option 2: #%

Continuing Benefit Period Percentage:
Option 1: #% of Pre-disability Earnings
Option 2: #% of Pre-disability Earnings

The following section is used only in incremental plans:
Maximum Monthly Benefit: The lesser of:
- $5,000;
- 60% of your Pre-disability Earnings; or
- your Scheduled Monthly Benefit.

Minimum Monthly Benefit: $100

Scheduled Monthly Benefit (Monthly Benefit): An amount you elect in increments of $500.

Corresponding Scheduled Monthly Benefit Percentage: Your Scheduled Monthly Benefit divided by your Pre-disability Earnings.

Eligibility Waiting Period for Coverage:
Option 1: X days/weeks/months of continuous service
Option 2: X days/weeks/months of continuous service
You will be eligible for coverage on the first day of the month on or next following the date on which You complete the Eligibility Waiting Period for Coverage.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer in an eligible class under the Prior Policy.

Schedule of Insurance

Elimination Period:
Option 1: X day(s)
Option 2: X day(s)

Maximum Duration of Benefits Table

Age When Disabled	**Benefits Payable**
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months]

Definitions

[Actively at Work means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for [Your usual number of hours.] 1

[We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.] 2

Active [Employee] means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.] 1

Any Occupation means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of: 1

1) [the product of Your Indexed Pre-disability Earnings and the [Initial] Benefit Period Percentage]; or 2,3
2) [the Maximum Monthly Benefit.]] 4

Bonuses means the [monthly average of monetary] bonuses You received from [the Employer] [over: 1,2

1) the [X month] period ending [immediately prior to the date] You became Disabled; or 3,4
2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]] 5

Commissions means the [monthly average of monetary] commissions You received from [the Employer] [over: 1,2

1) the [X month] period ending [immediately prior to the date] You became Disabled; or 3,4
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]] 5

[Current Monthly Earnings means [Monthly] earnings You receive from:

1) [the Employer; and 1
2) other employment;]

while You are Disabled.

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly] Earnings.] 2 3

[Current [Monthly] Earnings also includes the pay You could have received for another job or a modified job if: 4

1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.]

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of Any Occupation as a result of:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.]

Disability or means You are prevented from performing one or more of the Essential Duties of:

Disabled

1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] during the Elimination Period; and
2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must result from:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.]

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]

Disability or Disabled

means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period;
2) Your Occupation, for the [24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings;
3) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] after that, [for the next 12 months]; and
4) after that, Any Occupation .

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.]

Your Disability must be the result of:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, [or a Reasonable Alternative Job offered to You by the Employer,] alone, does

not mean that You are Disabled.]

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.]] 13 14, 15

[Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] during the Elimination Period; 1
2) Your Occupation [or a Reasonable Alternative Job offered to You by the Employer] [for the 24 months] following the Elimination Period, and as a result Your Current Monthly Earnings are [less than 80%] of Your [Indexed] Pre-disability Earnings; and 2,3 4, 5
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] but Your Current Monthly Earnings are [equal to or greater than 80%] of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of [12 months] from the original date of Disability, or until such time as Your Current Monthly Earnings are [less than 80%] of Your Pre-disability Earnings, whichever occurs first. [For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by the Employer, or another employer, and You refused the offer.] 6 7 8 9 10

Your Disability must result from:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

[Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation [or a Reasonable Alternative Job offered to You by the Employer,] alone, does not mean that You are Disabled.] 11 12

[**Reasonable Alternative Job** means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay [equal to or greater than 80%] of Your [Indexed] Pre-disability Earnings.] 13 14, 15

Elimination Period means the [longer of the] number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable [or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law]. 1 2

Employer means the [Policyholder]. 1

Essential Duty means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.] 1

Indexed Pre-disability Earnings

means Your Pre-disability Earnings adjusted annually by adding the lesser of:

1) [10%;] or
2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for [12 consecutive months,] provided You are receiving benefits at the time the adjustment is made. [A maximum of [5] adjustments may be made.]

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W].

Mental Illness

means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

[Monthly] Benefit

means a [monthly] sum payable to You while You are Disabled, subject to the terms of The Policy. [Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.]

Monthly Income Loss

means Your Pre-disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits

means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuan to any:

1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the result of membership in or association with any group, association, union or other organization;
4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
6) [mandatory "no-fault" automobile insurance plan;]
7) disability benefits under:

a) the United States Social Security Act or alternative plan offered by a state or municipal government;
b) the Railroad Retirement Act;
c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
d) similar plan or act;

that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or 11

8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under the Employer's Retirement plan;
2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;] 12
3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or 13
5) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
   d) similar plan or act;

   that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.] 14

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of: 15

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim. 16

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.]

Definitions

Participating [Employer]

means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.] 1

Physician

means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Pre-disability Earnings

means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]: 1

1) the [monthly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for: 2
   a) the [X tax] year(s) just prior to the date of Disability; or 3
   b) the number of months You were employed in this capacity, if less than above period; and
2) [not] contributions You make through a salary reduction agreement with the Employer to: 4
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section125 plan,

   for the same period as above.

Pre-disability Earnings [does not] include [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital. 5,6

Pre-disability Earnings

means, [for specific class description if applicable] Your average [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period: 1,2 3, 4

1) [not] including contributions you make through a salary reduction agreement with the Employer to: 5
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense reimbursements for the same period as above. 6,7

Pre-disability Earnings

means, [for specific class description if applicable], Your regular [monthly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], 1,2 3

1) [not] including contributions you make through a salary reduction agreement with the Employer to: 4
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions and tips and tokens] overtime pay or expense reimbursements for the same period as above.] 5,6

[However, if You are an hourly paid Employee, Pre-disability Earnings means the product of: 7

1) the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by;
2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.]

[Prior Policy means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date. 1,2

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, [any necessary and feasible: 1

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.]

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].] 1

[Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) [a profit sharing plan; 1
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.]

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

[Substance includes alcohol and drugs but excludes tobacco and caffeine.] 1

The Policy means the policy which We issued to [The Policyholder under the policy number] shown on the face page. 1

Tips [and Tokens] means the [monthly average of monetary] tips and tokens You received from [the Employer] [over: 1,2,3

1) the [X month] period ending [immediately prior to the date] You became Disabled; or 4,5
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]] 6

Definitions

Trust	means [the trust fund established by XXX.]	1
We, Our, or Us	means [the insurance company named on the face page of The Policy.]	1
Your Occupation	means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.	
	[If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.]	1
	[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.]	2
You or Your	means the person to whom this certificate is issued.]	

Eligibility and Enrollment

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:

1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage. 1

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]

Enrollment: *How do I enroll for coverage?*

[For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer. 1

For coverage under Option 2, You must enroll.] To enroll [for coverage]You must: 2

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.] 3

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll [or if You enroll for a Monthly Benefit Amount greater than the Guaranteed Issue Amount]:] 4, 5

1) You must give Us Evidence of Insurability satisfactory to Us; and 6
2) [You may only enroll: 7
   a) during an [Annual Enrollment Period] designated by the Policyholder; or 8
   b) within [31 days] of the date You have a Change in Family Status.] 9

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.]

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability may include, but will not be limited to:

1) [a completed and signed application approved by Us; 1
2) a medical examination;
3) an attending Physician'sd statement; and
4) any additional information We may require.] 2

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy.

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

1) [You get married [or You execute a domestic partner affidavit]; 1
2) You and Your Spouse divorce [or You terminate a domestic partnership];
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse [or domestic partner] dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.]

Period of Coverage

Effective Date: *When does my coverage start?*

[If You are not required to contribute toward The Policy's cost,] Your coverage will start: 1

1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or 2
2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.] 3

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of: 4

1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then; 5,6
2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible; 7,8 9
3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or] 10,11
4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.] 12,13

Deferred Effective Date: *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;] 1

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day. 2 3

[Changes in Coverage: *Can I change my benefit option?*

[You may change Your benefit option only:
1) during an Annual Enrollment Period; or
2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:
1) [the first day of the month following the Annual Enrollment Period;] or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:
1) the date You enroll for the change; or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:
1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.]]

Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:
1) the Deferred Effective Date provision; and
2) Pre-existing Conditions Limitations.]

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*

[If You were: 1

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of : 2

1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Monthly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of: 3

1) the [Monthly] Benefit which was paid by the Prior Policy; or
2) the [Monthly] Benefit provided by The Policy.]

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [monthly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] 4,5,6 of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination:
When will my coverage stop?

Your coverage will end on the earliest of the following:

1)	[the date] The Policy terminates;	1
2)	[[the date] The Policy no longer insures Your class;]	2,3
3)	[the date] premium payment is due but not paid by the Employer;	4
4)	[the last day of the period for which You make any required premium contribution;]	5
5)	[the last day of the month on or next following the month in which Your Employer terminates Your employment;]	6
6)	[the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason;	7,8
7)	[the date Your Employer ceases to be a Participating Employer];	9

unless coverage is extended under the Continuation Provisions.

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium [by the Employer;] and 1
3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.] 2

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.] 3,4 5

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.] 6 7

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.] 8 9

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.] 10 11

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.] 12,13 14

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]] 15 16,17 17

Period of Coverage

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) [during the Elimination Period while You remain Disabled by the same Disability; and 1
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.]

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You:

1) [after the Elimination Period; and 1
2) for as long as benefits are payable.]

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Conversion Right:
If my coverage under the Policy stops, do I have a right to conversion?

If Your insurance terminates because:

1) Your employment ends [for a reason other than Your retirement]; or 1
2) You are no longer in an eligible class;

and if:

1) [You have been continuously insured for at least [12 consecutive months] under The Policy or under both this Policy and the Prior Policy;] 2, 3
2) [You are under the Policy Age Limit, if any is shown in the Schedule of Insurance;] 4
3) a Disability is not preventing You from performing duties of Your Occupation;
4) [the insurance for Your class, or] The Policy has not terminated; 5
5) [You are not eligible for coverage under The Policy under another class; and] 6
6) You are not eligible or covered for similar benefits under another group policy [or an individual policy]; 7

then You are eligible to enroll for personal insurance under another group policy called the group long term disability conversion policy.

How do I convert my Coverage?

To obtain coverage under the group long term disability conversion policy, You must:

1) send Us a written enrollment request; and
2) pay the required premium and enrollment fee for the conversion policy;

within [31 days] of the termination of Your insurance. 1

If You meet the preceding conditions, We will issue You a certificate of insurance under the group long term disability conversion policy. Such coverage will:

1) be issued without Evidence of Insurability;
2) be on one of the forms then being issued by Us for conversion purposes; and
3) be effective on the day following the date Your insurance under The Policy terminates.

The coverage available under the conversion policy may differ from The Policy. We will determine the terms of the group long term disability conversion policy, including:

1) the type and amount of coverage provided; and
2) the premium payable;

based on the kinds of insurance provided by the group long term disability conversion policy at the time such enrollment request is made.

Disability Benefit: *When do I qualify for Disability Benefits?*

We will pay You a Monthly Benefit if You:

1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness And Substance Abuse Benefits: *Are benefits limited for Mental Illness [or Substance Abuse?]*

If You are Disabled because of:

1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;
3) alcoholism [which is under treatment]; or 1
4) [the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance]; 2

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

[Benefits will be payable for a total of [24 months,] unless at the end of the [24 month] period: 3,4,5

1) You are confined in a hospital or other place licensed to provide medical care for the disabling condition, in which case:
   a) benefits will continue during the confinement; and
   b) if You are still Disabled when discharged, benefits will continue for a recovery period of up to [90 days;] and 6
   c) if You become re-confined during the recovery period for at least [14 consecutive days,] benefits will continue during the confinement and another recovery period of up to [90 days;] 7 8

or

2) You continue to be Disabled and, [within 7 days] become confined in a hospital, or other place licensed to provide medical care, for the disabling condition for at least [14 consecutive days,] in which case benefits will be paid while You are so confined.] 9 10

Substance Abuse Limitation: *Are benefits limited for alcoholism or Substance Abuse?*

If You are Disabled because of:

1) alcoholism [under treatment]; or 1
2) the non-medical use of narcotics, [sedatives, stimulants, hallucinogens, or any other such substance]; 2

then, subject to all other Policy provisions, benefits will be payable for [as long as] You are: 3

1) confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) actively participating in a rehabilitative program approved by Us.

Recurrent Disability:
What happens if I recover but become Disabled again?

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are [less than one-half (1/2) the number of days of Your Elimination Period.] 1

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within [6] months of the return to work, 2

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [6] months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a New Maximum Duration of Benefits. 3

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit: *How are my Disability benefits calculated [during the Initial Benefit Period]?*

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefit [during the Initial Benefit Period] as follows: 1

1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage ; 2, 3
2) compare the result with the Maximum Benefit ; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

How are Disability benefits calculated?

If You remain Disabled after the Elimination Period, We will calculate Your Monthly Benefits as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage; and from this product subtract all Other Income Benefits; and
3) identify the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows: 1

1) multiply Your Pre-Disability Earnings by the [Initial] Benefit [Period] Percentage; 2,3
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess. 4

The [12 consecutive month] period will start on the last to occur of: 5

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, [during the Initial Benefit Period,] We will calculate Your Monthly Benefit as follows: 6

1) multiply Your Monthly Income Loss by the [Initial] Benefit [Period] Percentage; 7,8
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Calculation of Monthly Benefit: Return to Work Incentive*: How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows: 1

1) multiply Your Pre-disability Earnings by the Benefit Percentage;
2) multiply Your Pre-disability Earnings by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit during this period. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess. 2

If You are Disabled, but You are not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) multiply Your Monthly Income Loss by the Secondary Benefit Percentage, and from this product subtract all Other Income Benefits; and
3) compare the results with the Maximum Benefit.

The calculation giving the least amount is Your Monthly Benefit.

During the Continuing Benefit Period, if [You are not receiving benefits under the Return to Work 3

Incentive, but] You are receiving benefits under Social Security Disability or Social Security Retirement plans, or an alternative plan for federal, state or municipal employees, We will determine Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

During the Continuing Benefit Period, if You are not receiving benefits [under the Return to Work Incentive, or] under Social Security Disability or Social Security Retirement plans or an alternative plan for federal, state or municipal employees, We will determine Your Monthly Benefit as follows: 4

1) multiply Your Pre-disability Earnings by the Continuing Benefit Period Percentage;
2) multiply Your Monthly Income Loss by the Initial Benefit Period Percentage, and deduct all Other Income Benefits; and
3) deduct all Other Income Benefits from the Maximum Benefit.

The result of the calculation giving the least amount is Your Monthly Benefit.

Calculation of Monthly Benefit: *What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*

If the sum of Your [Monthly Benefit, Current Monthly Earnings and Other Income Benefits] exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. 1

[However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.] 2

[If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.] 3

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to [12 consecutive months] as follows: 1

1) compare the Scheduled Monthly Benefit with the Maximum Benefit; and
2) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds [100%] of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess. 2

The [12 consecutive month] period will start on the last to occur of: 3

1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1) multiply Your Monthly Income Loss by the Corresponding Scheduled Monthly Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*

Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*

If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Denial of Social Security Benefits: *After the Initial Benefit Period expires, is there any allowance if I am ineligible for Social Security?*

If Your Disability prevents You from performing the Essential Duties of Any Occupation, but Your claim for disability benefits under The United States Social Security System, or an alternative plan for federal, state or municipal employees:

1) was denied because You have not worked under these systems long enough to be eligible for disability benefits, Your Monthly Benefit during the Continuing Benefit Period will be calculated using the Initial Benefit Period Percentage; or
2) is still pending at the time the Initial Benefit Period expires, benefits may be paid at the Initial Benefit Period Percentage until the earlier to occur of:
    a) the 12th month following the expiration of the Initial Benefit Period; or
    b) the final adjudication of Your claim for Social Security disability benefits.

Termination of Benefit Payment:
When will my benefit payments end?

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]] 1,2
4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;] 3
5) the date of Your death;
6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.] 4
7) [the last day benefits are payable according to the Maximum Duration of Benefits Table; or] 5
8) [the date Your Current Monthly Earnings: 6
   a) are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation [or a Reasonable Alternative]; or 7,8 9
   b) [are greater than the lesser of: the product of Your [Indexed] Pre-disability Earnings and the [Initial] Benefit [Period] percentage; or the Maximum Monthly Benefit if You are receiving benefits for being Disabled from Any Occupation;]] 10,11, 12,13
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
   a) [modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative; 14
   b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation or a Reasonable Alternative;
   c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
   d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

   provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation;] or
11) [the date You receive retirement benefits from any employer's Retirement plan, unless: 15
   a) You were receiving them prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in Rehabilitation?*

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1) Family Care means the care or supervision of:
   a) Your children under age [13]; or 1
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) the maximum monthly deduction allowed for each qualifying child or family member is:
   a) [$350] during the first [6] months of Rehabilitation ; and 2,3
   b) [$175] thereafter; 4

   but in no event may the deduction exceed the amount of Your monthly earnings;
3) Family Care Credits may not exceed a total of [$2,500] during a calendar year; 5
4) the deduction will be reduced proportionally for periods of less than a month;
5) the charges for Family Care must be documented by a receipt from the caregiver;
6) the credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitation program; or
   b) Family Care Credits for [24] months have been deducted during Your Disability; and 6
7) no Family Care provided by a someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed [80%] of Your [Indexed] Pre-disability Earnings. 7,8

Cost-Of-Living Adjustment: *How do my benefits keep pace with inflation?*

We [will] adjust Your Monthly Benefit for increases in the cost-of-living if: 1

1) You have been Disabled for [12 consecutive months]; and 2
2) [You are receiving benefits;] [and 3
3) Your Current Monthly Earnings are less than or equal to 20% of Your Pre-disability Earnings;] 4

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.] 5

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

1) determining the lesser of:

a) [3%]; or 6
b) [1/2] the percentage change in the Consumer Price Index; 7

2) multiplying the resulting percentage (%) times the Monthly Benefit for Disability being received; and
3) adding the resulting amount to Your Monthly Benefit.

When will the Cost-of-Living Adjustments end?

You will not receive a Cost-of-Living Adjustment after:

1) You cease to be Disabled; [or 8
2) You have received [5] adjustments;] or 9
3) The Policy terminates.

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered]. 10

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability* Benefits?

If You were receiving a Monthly [Disability] Benefit at the time of Your death [and You had been receiving such benefits [for at least 12 months]], We will pay a [Survivor Income Benefit], when We receive proof satisfactory to Us: 1, 2, 3, 4

1) of Your death; and
2) that the person claiming the benefit is entitled to it.

[We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.] 5

[[We will pay the Survivor Income Benefit: 6, 7

1) to the beneficiary You designated; or
2) if no beneficiary has been designated:]
   a) to Your Surviving Spouse; or
   b) if no Surviving Spouse, in equal shares to Your Surviving Children;
   c) [if no Surviving Spouse or Surviving Children, to Your estate.] 8

[If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.] 9

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

[The Survivor Income Benefit [will be equal to [3] times your Monthly Benefit/is calculated as [3] times the lesser of]: 10,11

1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
2) The Maximum Monthly Benefit.]

[To designate or change Your designation of beneficiary, You must file a written notice with Us on any form satisfactory to us. Whether You are living or not, any change will relate back and take effect as of the date You signed the written notice. We are not liable for payment of benefits made before receiving written notice.] 12

Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. ["Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.] 13

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance who are under age [19].The term Surviving Children will also include any other children related to You by blood or marriage [or domestic partnership] and who: 14, 15

1) lived with You in a regular parent-child relationship; and
2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

[In the event that You are diagnosed with a Terminal Illness while You are: 16

1) eligible for a Monthly Benefit under the Policy; and
2) at least [6] Monthly Benefit Payments remain payable to You; 17

We will pay the Survivor Income Benefit to You on an accelerated basis in one lump sum if: 18

1) [You submit a request that the Survivor Income Benefit be paid on an accelerated basis; and
2) We receive proof that You have been diagnosed with a Terminal Illness.

If the Survivor Income Benefit is paid on an accelerated basis, no additional benefit will be payable under this benefit upon Your death.]
[Terminal Illness or Terminally Ill means a life expectancy of [6] months or less.] 19

Extended Earnings Protection Benefit: *Will benefits continue to be paid after my return to work if my earnings are less than Pre-disability Earnings?*

This benefit protects Your earnings level after You have returned to work following a period of Disability. To qualify for this Extended Earnings Protection Benefit, You must:

1) have been Disabled under The Policy and received a Monthly Benefit from Us;
2) now be working [Full-time] for the Employer [or another employer;] 1,2
3) be performing all the Essential Duties of Your Occupation [or another occupation;] 3
4) as a result of having been so Disabled, be currently earning less than [80%] of Your Pre-disability Earnings; and 4
5) provide to Us each month, satisfactory proof of Your Current Monthly Earnings.

The Extended Earnings Protection Benefit will be the lesser of:

1) the Maximum Monthly Benefit ; or
2) Your Monthly Income Loss multiplied by the [Initial] Benefit [Period] Percentage. 5,6

The Extended Earnings Protection Benefit will end on the earliest of:

1) the date benefits have been payable for a maximum duration of [24] months; 7
2) the date You are earning at least [80%] of Your Pre-disability Earnings; or 8

the date You fail to submit to Us satisfactory proof of Your Current Monthly Earnings.

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

1) Your Disability is covered by this Policy;
2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such workplace modification shall not exceed the amount equal to the amount of the Maximum Monthly Benefit.

We have the right, at Our expense, to have You examined or evaluated by:

1) a Physician or other health care professional; or
2) a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

1) the proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Employee.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this Policy.

Pension Contribution Benefit*: Does The Policy also cover contributions to a Pension Plan?*

[If You:

1) become Disabled while You are covered under this Pension Contribution Benefit;
2) remain Disabled for [365 days] of one continuous period of Disability; and 1
3) are receiving a Monthly Benefit under The Policy;]

We will pay a monthly Pension Contribution Benefit to the trustee or administrator of Your Pension Plan for deposit to Your pension account. The Pension Contribution Benefit will be [the 2 least of:

1) [15%] of Your monthly Pre-disability Earnings; 3
2) [$2,500]; 4
3) the amount of the average monthly tax deferred contributions the Employer made to Your Pension Plan during the [12 calendar months] prior to becoming Disabled.] 5

We will make payments under this benefit according to the rules and regulations of the Internal Revenue Service and the provisions of Your Pension Plan. We will make any such payment that cannot be paid to the trustee or administrator of Your Pension Plan to a deferred annuity account designated by You.

No Pension Contribution Benefit will be payable after Your Monthly Benefit terminates.

Pension Plan means, for the purpose of this Pension Contribution Benefit, a qualified defined contribution pension Plan, profit sharing Plan, or other Plan approved by Us, in which You are participating as a result of Your employment with the Employer.

Infectious And Contagious Disease Benefit: *If it is disclosed that I carry an Infectious and Contagious Disease, will The Policy cover the income lost as the result of limitations placed on my license or reduced patronage?*

You will be eligible to receive an Infectious and Contagious Disease Benefit when You have been covered by this benefit for a period of [12 months], and You provide verification that: 1

1) You carry an Infectious and Contagious Disease; and
2) You first tested positive for the Infectious and Contagious Disease after the effective date of this benefit; and
3) You are not Disabled but one or more of the following has happened:
   a) Your license to practice Your Occupation has been revoked; or
   b) You or Your license have limitations or restrictions imposed, and as a result You are unable to perform all of the Essential Duties of Your Occupation; or
   c) it has been disclosed that You are infected with an Infectious and Contagious Disease; and
4) throughout a period of time equal in length to the [Elimination Period,] You have suffered a loss of earnings in excess of [20]% of Your Pre-disability Earnings immediately prior to disclosure; and 2 3
5) You have never refused to be immunized against the Infectious and Contagious Disease for which You are claiming this benefit.

What qualifies as an Infectious and Contagious Disease?

To qualify as an Infectious and Contagious Disease, a disease must be:

1) categorized by the Center for Disease Control as Infectious and Contagious; and
2) life threatening to You or persons with whom You may come in contact.

What will my monthly benefit be?

[We calculate the benefit as the lesser of;

1) the Maximum Monthly Benefit; or
2) Your earnings loss multiplied by the [Initial] Benefit [Period] Percentage. 4,5

Your earnings loss is determined by deducting Your Pre-disability Earnings after disclosure from Your Pre-disability Earnings prior to disclosure.]

How long may an Infectious and Contagious Disease Benefit be paid?

We will stop paying this benefit on the earliest of:

1) the date Your Pre-disability Earnings are equal to or greater than [80]% of Your Pre-disability Earnings prior to disclosure; 8
2) the date You die;
3) the date You become eligible for Disability benefits under the terms of this Policy;
4) the date We determine You have not made every effort to continue to work in Your Occupation [on a full-time basis]; 9
5) the date You no longer participate with Us in seeking and applying for suitable alternate work based on Your training, education, experience, and comparable income;
6) the end of the Maximum Duration of Benefits [Table/Payable] of The Policy; or 10
7) [the end of [2 years] from the date this benefit begins.] 11,12

Activities of Daily Living Benefit:
What is the Activities of Daily Living Benefit?

We will pay You the Activities of Daily Living Benefit if:

1) a Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform [two or more] Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment: 1
   a) [during or after the Elimination Period, and] 2
   b) for at least [30 consecutive days;] and 3
3) the Disability and such impairment or inability begins while You are covered under this benefit.

The Activities of Daily Living Benefit will be [10% of Your Monthly Income Loss, but not greater than the lesser of: 4

1) [$5000]; or 5
2) the Maximum Monthly Benefit.]

[The maximum payment period for this benefit will be [X years].] 6,7

[We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Activities of Daily Living Benefit for each day of covered loss.] 8

The Activities of Daily Living Benefit will not:

1) be reduced by Other Income Benefits;
2) increase or reduce other benefits under The Policy; [or 9
3) be subject to the Cost of Living Adjustment.]

You are not restricted in any way as to Your use of this Activities of Daily Living Benefit.

We will stop paying You the Activities of Daily Living Benefit on the date:

1) Your Monthly Benefit terminates;
2) You are not Cognitively Impaired and You are able to perform [five or more] ADLs;[or 10
3) You reach the maximum payment period shown in this benefit.] 11

Cognitively Impaired means You suffer severe deterioration, or loss of:

1) memory;
2) orientation; or
3) the ability to understand or reason;

so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.

Activities of Daily Living (ADLs) means the following functions performed with or without equipment or adaptive devices:

1) bathing Yourself by being able to either:
   a) wash Yourself in a tub or shower devices; or
   b) give Yourself a sponge bath;
2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
4) transferring from bed to chair or wheelchair; or
5) bladder and bowel control by being able to either:
   a) voluntarily control bowel and bladder function; or
   b) maintain a reasonable level of person hygiene, if You are not so able; and
6) feeding Yourself, once the food has been prepared and made available to You.

Accidental Dismemberment and Loss of Sight Benefit: *What benefits are payable for dismemberment or loss of sight due to an Injury?*

If, while covered under The Policy, You sustain an accidental bodily injury, which results in any of the following Losses within [90 days] after the date of accident, We will pay the Monthly Benefit, after the Elimination Period, for at least the number of months shown opposite the Loss. 1

For Loss of	**Minimum Number of Monthly Benefit Payments**
[Both Eyes	46
Both Hands or Both Feet	46
One Hand and One Foot	46
One Hand and One Eye	46
One Foot and One Eye	46
One Hand or One Foot	23
One Eye	15
Thumb and Index Finger of Either Hand	12]

2

3

[**Loss** means, with regard to:

1) hands and feet, actual severance through or above wrist or ankle joints;
2) eyes, entire and irrecoverable Loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints.]

If You incur more than one of the listed Losses as the result of the same accident, the number of monthly benefit payments that You will receive will be limited to the Loss for which the greatest number of monthly benefit payments are shown in the above Schedule.

Benefits may continue to be payable to You after the Minimum Number of Monthly Benefit Payments have been made, if You remain Disabled. If You die after the Elimination Period, but before the minimum number of monthly benefit payments have been made, the remaining monthly benefit payments will be made to Your estate.

Business Protection Benefit: *Are additional Disability Benefits paid to compensate for business revenue lost when I am Disabled?*

We will pay a [Monthly] Business Protection Benefit to the Employer if You:

1) are actively engaged on a full-time basis in the business of the Employer, and fall within a class of persons that is covered by The Policy, and You are:
   a) the sole proprietor of the Employer if the Employer is a sole proprietorship; or
   b) a general partner of the Employer if the Employer is a partnership; or
   c) a Member of a Limited Liability Company if the Employer is a Limited Liability Company; and
2) become Disabled while You are covered under this Business Protection Benefit; and
3) remain Disabled for the longer of:
   a) the Elimination Period; or
   b) [90] consecutive days; and
4) are receiving a [Monthly] Benefit for the Disability under the group insurance policy. 1

We calculate the [Monthly] Business Protection Benefit as the [lesser of: 2

1) [15]% of Your [Pre-disability Earnings]; or
2) [$2,500].] 3,4 5

Is a benefit paid if I am Disabled and Working?

[If You are Disabled and Working, We will proportionately reduce the Business Protection Benefit according to the following formula: 6

Business Protection Benefit Payable = (A - B) x C
A

where
A = Your Pre-Disability Earnings
B = Your current [Monthly] earnings
C = The Business Protection Benefit payable if You were Totally Disabled.]

How long will this benefit be paid?

We will stop paying the Business Protection Benefits on the earliest of: 7

1) [the date You cease to be Disabled;
2) the date [12 monthly] benefits have been paid under this Benefit;
3) the date You cease to be the proprietor, a partner, or a [Member,]if applicable, of the Employer; or
4) the date You die.

In no event will this benefit continue to be payable beyond a date shown in the Termination of Benefit Payment provision.]

Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:
The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.

[**Rehabilitation Bonus:** *What happens if I successfully complete an approved program of Rehabilitation?*

If You successfully complete an approved program of Rehabilitation, You will be eligible for an additional benefit equal to [1] times Your Monthly Benefit. 1 2

The benefit will be subject to all applicable terms and conditions of the Policy. We will pay the benefit in one lump sum.]

Exclusions and Limitations

Exclusions: *What Disabilities are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability: 1

1) unless You are under the Regular Care of a Physician;
2) that is caused [or contributed to by] war or act of war (declared or not); 2
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused [or contributed to] by an intentionally self-inflicted [Injury]; 3,4
6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer; 5
7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment. 6

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that 1
results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You 2
become Disabled:

1) You have not received Medical Care for the condition for [365] consecutive day(s)] while insured under The Policy; or 3
2) [You have been continuously insured under The Policy for [365] consecutive day(s)]. 4,5

Pre-existing Condition means:

1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or 6
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse; 7

for which You received Medical Care during the [730] day period that ends the day before: 8

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number. 1,2,3 4

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.] 5 6

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim. 1, 2 3 4

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within [15 days] after We receive a notice of claim.] 5 6

Proof of Loss: *What is Proof of Loss?*

[Proof of Loss may include but is not limited to the following: 1

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current [Monthly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.] All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss*: When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if: 1

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than [1 year] after it is due, unless You are not legally competent. 2

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request. 3

Claim Payment:
When are benefit payments issued?

When We determine that You;
1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as Proof of Loss satisfactory to Us is received]. 1

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid:
To whom will benefits for my claim be paid?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to [$1,000] to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid. 1

Claim Denial:
What notification will I receive if my claim is denied?

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal:
What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:
1) You must request a review upon written application within:
   a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or 1
   b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and 2
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

[Social Security:
When must I apply for Social Security Benefits?

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required: 1
1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

Benefit Estimates:
How does the Company estimate Disability benefits under the United States Social Security Act?

We reserve the right to reduce Your [Monthly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly] Benefit by the estimated amount. Your [Monthly] Benefit will not be reduced by estimated Social Security disability benefits if:
1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and

3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly] Benefit by an estimated amount and:

1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision .

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) [retroactive awards received from sources listed in the Other Income Benefits definition; 1
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.]

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.] 1

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) [You; 2
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate.]
2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered; 3
3) refer Your unpaid balance to a collection agency; and

pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You: 1

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Reimbursement:
What are the Company's Reimbursement Rights?

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

a) a legal judgment;
b) an arbitration award; or
c) a settlement or otherwise;

You must reimburse Us for the lesser of:

a) the amount of payment made or required to be made by Us; or

the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Legal Actions:
When can legal action be taken against Us?

Legal action cannot be taken against Us:

1) sooner than [60 days] after the date proof of loss is given; or 1
2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy. 2**,3**

Insurance Fraud:
How does the Company deal with fraud?

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud. 1 2 3

Misstatements:
What happens if facts are misstated?

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.] 1

Policy Interpretation:
Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

[Rider Language This rider forms a part of [The Policy to which it is attached] and [all] certificates given in connection with 1, 2, 3
The Policy.

This rider becomes effective [on the later to occur of: 4

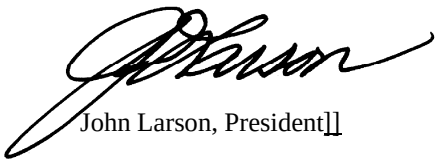
a) the effective date of the Policy or certificate to which this rider is attached; or
b) the first day of the month on or next following the date e accept Your application and required premium.]

[In consideration of the required additional premium and submission of satisfactory evidence of insurability, the following 5
benefit is added to The Policy and certificates:]

In all other respects, The Policy and certificates remain the same.

Signed for **National Guardian Life Insurance Company**
[

[



Sherri Kliczak, Secretary John Larson, President]] 6

ARKANSAS - Statement of Variable Language

Group Long Term Disability Income Insurance

NHCRTLTD 4/08 et al

Introduction: This Statement of Variable Language (SOVL) shows the language we intend to substitute, delete or change. Variable language is identified by brackets ([ ]) in each module of Form(s) NHCRTLTD 4/08 et al. Each module is identified in this SOVL and each variable within each module is numbered on the form. These numbers directly correspond with the numbers on the SOVL for the appropriate module.

Constant Variables	
1	Wherever the term "the Employer" appears, it may be changed to "Your employer" or some other term to accommodate non-Employer groups
2	Wherever the term "Employee" appears, it may be changed to "Member" or "Associate" or some other term, to reflect the case specifics
3	Wherever the term "Policyholder" appears, it may be changed to "Employer" or "Organization" or some other term to reflect the case specifics
4	Wherever "Monthly" appears, may be changed to "weekly" or some other period to reflect the case specifics
5	Wherever a reference to "Your Spouse" appears, it may be deleted if Spouse Disability coverage not offered; if that is the case, all other references will agree with no spouse coverage offered (eg. he or she deleted)
6	Wherever the word "Policy" appears, it may be replaced by "Plan" or some other term to accommodate the structure of the Policyholder
7	National Guardian Life Insurance Company may be National Guardian

Form #	Module #	Description	Variable #	Description of Variables	Use
NHCRTLTD 4/08		Face page	1	Fill-in information will vary by Policyholder; fill-in items may be deleted in whole or in part and may be located on Schedule of Insurance	
			2	Included when administrator involved; fill-in information will vary dependent on the specific administrator	
			3	signatures will change if officers change	
			4	may be some other description of coverage, or may be deleted	
			5	may be in or out; 30 days may be 45, 60, 90 or 180	
			6	Table of Contents may be expanded and detailed and may appear on next page or a separate page	
NHCRTLTD-SCH (AR) 4/08		Schedule of Insurance		language on page is illustrative and will be edited to reflect the case specifics	
NHCRTLTD-DEF 4/08		Definitions		Note: Defintions may be deleted in their entirety if not applicable and/or placement in certificate may change	
		Actively at Work	1	actual number of hours may be stated here	
			2	paragraph may be deleted; specific items may be deleted or amended to meet the case specifics.	
		Active [Employee]	1	description may be revised to meet the case specifics; Employee may be Member or Associates or some other term to reflect the case specifics	
		Any Occupation	1	clause and items 1 and 2 may be deleted	
			2	may be: 40-100% of Your Indexed Pre-disability Earnings	
			3	may be deleted	
			4	Maximum Monthly Benefit may be shown here	
		Bonuses	1	clause may be deleted or "monetary" may be deleted	
			2	clause and items 1 and 2 may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			3	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			4	may be actual date	
			5	may be specific period noted above	
		Commissions	1	clause may be deleted or "monetary" may be deleted	
			2	clause and items 1 and 2 may be deleted	
			3	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			4	may be actual date	
			5	may be specific period noted above	
		Current Monthly Earnings	1	may show other source of income, eg: "Your law practice" etc…	
			2	may be deleted	
			3	may be 6-24 months	
			4	may be deleted	
		Disability or Disabled		no variables	
		Disability or Disabled	1	may be deleted	
			2	may be deleted	
			3	may be 60-100%	
			4	may be deleted	
			5	may be deleted	
			6	may be 60-100%	
			7	may be 6-24 months or expressed in years	
			8	may be 60-100%	
			9	may be deleted	
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	
			13	may be 60-100%	
			14	may be deleted	
		Disability or Disabled	1	may be 6-60 months or expressed in years	
			2	may be 60-100%	
			3	may be deleted	
			4	may be deleted	
			5	may be 12-60 months or expressed in years	
			6	may be deleted	
			7	may be 60-100%	
			8	may be 6-24 months or expressed in years	
			9	may be 60-100%	
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			13	may be deleted	
			14	may be 60-100%	
			15	may be deleted	
		Disability or Disabled	1	may be deleted	
			2	may be deleted	
			3	may be 6-60 months or expressed in years	
			4	may be 60-100%	
			5	may be deleted	
			6	may be deleted	
			7	may be 60-100%	
			8	may be 6-24 months or expressed in years	
			9	may be 60-100%	
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	
			13	may be deleted	
			14	may be 60-100%	
			15	may be deleted	
		Elimination Period	1	may be deleted	
			2	may be deleted	
		Employer	1	may be Participating Employer or some other description, or Employer will be named	
		Essential Duty	1	number of hours will be shown - will be 20-80; or sentence deleted	
		Indexed Pre‑disability Earnings	1	percentage may be from 3-15	
			2	may be 12-36 months or expressed in years	
			3	entire clause may be deleted	
			4	may be 5-10	
			5	may be "approved by the Insurance Commissioner of the state in which the Policy is delivered."	
		Mental Illness			
		[Monthly] Benefit	1	the entire phrase may or may not be included depending on case specifics	
			2	may be 9, 10, 11 or 12 months	
		Monthly Income Loss			
		Other Income Benefits		Note: the following definition of Other Income Benefits shows what we intend to use as a determination of other income benefits - for most Policyholders. However, we reserve the right to amend, alter or revise these definitions to reflect the nature of the Policyholder and/or accommodate his or her request	
			1	may be deleted	
			2	may be deleted	
			3	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			4	may be deleted	
			5	may be deleted	
			6	may be deleted	
			7	may be 80-100%	
			8	may be 80-100%	
			9	may be deleted	
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	
			13	may be deleted	
			14	may be deleted	
			15	may be deleted	
			16	may be deleted or may be 12 to 60 months	
		Participating [Employer]	1	description may be revised to meet the case specifics and to describe the participating entity.	
		Physician			
		Pre-disability Earnings	1	items from this list may be deleted to correspond with Policyholder composition	
			2	monthly may be annual or weekly	
			3	number will be 1 to 10 or "tax" may be deleted	
			4	may be deleted	
			5	may be deleted	
			6	any from this list may be deleted or other items may be added to reflect the case specifics	
		Pre-disability Earnings	1	description of class will be shown or reference deleted	
			2	monthly may be annual or weekly	
			3	any from this list may be deleted or other items may be added to reflect the case specifics	
			4	number will be 1 to 10	
			5	may be deleted	
			6	may be deleted	
			7	any from this list may be deleted or other items may be added to reflect the case specifics	
		Pre-disability Earnings	1	description of class will be shown or reference deleted	
			2	may be deleted	
			3	any from this list may be deleted or other items may be added to reflect the case specifics	
			4	may be deleted	
			5	may be deleted	
			6	any from this list may be deleted or other items may be added to reflect the case specifics	
			7	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
		Prior Policy	1	actual policy and insurance carrier may be stated here; this will be an accurate description of the Prior Policy	
			2	name of Employer/Policyholder may be stated here	
		Regular Care of a Physician			
		Rehabilitation	1	list may be amended, added to or items deleted to reflect current practices and/or advances in rehabilitation as available	
		Related	1	actual relationship may be stated or phrase deleted	
		Retirement Plan	1	list may be amended, added to or items deleted to reflect Policyholder's retirement plans	
		Substance Abuse	1	may be deleted	
		The Policy	1	Policyholder name and Policy number may be stated	
		Tips and Tokens	1	may be deleted	
			2	clause may be deleted or "monetary" may be deleted	
			3	clause and items 1 and 2 may be deleted	
			4	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			5	may be actual date	
			6	may be specific period noted above	
		Trust	1	trust may be named or described here	
		We, Our, or Us	1	National Guardian Life Insurance Company or National Guardian may be identified here	
		Your Occupation	1	may be deleted; may be used with next paragraph; more specific description may be used	
			2	may be deleted; may be used with preceding paragraph; more specific description may be used	
		You or Your			
NHCRTLTD-E&E 4/08		Eligibility and Enrollment			
		Eligible Persons: *Who is Eligible for Coverage?*			Optional module if language is not in Policy of Incorporation
		Eligibility Waiting Period for Coverage: *When will I become Eligible?*	1	may be deleted if no waiting period for coverage	Optional module if language is not in Policy of Incorporation
		Enrollment: *How do I enroll for coverage?*	1	sentences may be deleted; references to Option 1 and Option 2 will be deleted or will .reflect plans offered; Active Employees may be changed to reflect composition of the group and/or those eligible for which options offered	Optional module if language is not in Policy of Incorporation
			2	option(s) available may be stated here	
			3	may be deleted if no voice/electronic enrollment offered; specific instructions may be included here	
			4	entire section may be deleted or may be revised to accommodate Guaranteed Issue program	

Form #	Module #	Description	Variable #	Description of Variables	Use
			5	may be 31-60 days	
			6	reference to Annual Enrollment and/or Change in Family Status may be deleted or revised	
			7	Annual Enrollment may some other designation or time period	
			8	may be 31-60 days	
			9	may be deleted or Annual Enrollment may be referred to by some other designation	
		[Evidence of Insurability: *What is Evidence of Insurability?*	1	items in list may be added to or deleted; Written may include telephonic and/or electronic	Optional module if language is not in Policy of Incorporation
			2	may be "Our"	
		[Change in Family Status: *What constitutes a Change in Family Status?*	1	list may be added to or items may be deleted	Optional module if language is not in Policy of Incorporation
NHCRTLTD-PoC 4/08		Period of Coverage			
		Effective Date: *When does my coverage start?*	1	may be deleted or reference to "the Policy's costs" may be "the cost of coverage"	Optional module
			2	may be deleted	
			3	may be deleted	
			4	may be deleted or reference to "the Policy's costs" may be "the cost of coverage"	
			5	may be "the first day of the month following the date"	
			6	may be deleted	
			7	may be "the first day of the month following the date"	
			8	may be deleted	
			9	may be 31-60 days	
			10	may be "the first day of the month following the date"	
			11	may be deleted	
			12	may be deleted or may be some other reference	
			13	may be deleted	
		Deferred Effective Date: *Will coverage take effect if I am not Actively at Work on the date my coverage is to start?*	1	may be Complications of Pregnancy	Optional module
			2	may be deleted	
			3	may be deleted	
		Changes in Coverage: *Can I change my benefit options?*	1	either item may be deleted or a specific date maybe listed or may be at some other time or section may be deleted	Optional module
			2	may be 31-60 days	
			3	may be deleted	
			4	may be deleted or may reference options or dollar amounts specifically	
			5	section may be deleted	
			6	"the date" or "the first day of the month" may be some other time reference or item may be deleted	
			7	item 2 may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			8	Change in Family Status section may be deleted	
			9	may be 31-60 days	
			10	item 2 may be deleted	
			11	may be deleted or either item deleted	
			12	may be deleted or class described	
			13	may be deleted or class described	
			14	may be deleted or either item deleted	
		Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*	1	section may be revised to require eligibility under the Prior Policy or some other criteria based on language of the Prior Policy; either item may be deleted or second item may be "receiving benefits under the Prior Policy"	Optional module
			2	entire section may be deleted if no pre-existing condition limitation under the policy	
			3	may be deleted	
			4	may be Part-time, temporary or other kind of employee	
			5	date may be specified	
			6	may be 1-12 months	
		Termination: *When will my coverage stop?*	1	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	Optional module
			2	item may be deleted	
			3	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	
			4	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	
			5	item may be deleted	
			6	may be "the date" or other period of time	
			7	list may be amended, added to or items deleted	
			8	may be deleted or "Part time" may be added or replace "Full time"	
			9	may be deleted	
		Continuation Provisions: *Can my insurance be continued?*		NOTE: the specific types of contiuation listed in this provision may be added to based on the Employer's plan of continuation specific to his or her particular business needs and requirements	Optional module
			1	may be deleted	
			2	reference to class and/or Participating Employer may be deleted	
			3	provision may be deleted	
			4	may be non-medical	
			5	may be "for [30] days after the date" where 30 may be 30-365 or may be expressed in months	
			6	provision may be deleted	
			7	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			8	provision may be deleted	
			9	may be 12-52 and/or second clause deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			10	provision may be deleted	
			11	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			12	provision may be deleted	
			13	may be medical, non-medical or non-paid	
			14	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			15	provision may be deleted	
			16	May be 8-52 weeks; or may be replaced by "8-52 weeks, or longer if required by other applicable law."	
			17	may be deleted	
		Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*	1	either item may be deleted	Optional module
		Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*	1	items 1 or 2 may be deleted or specific date specified in item 2 or some other time period specified	Optional module
		Extension of Benefits for Total Disability: *Do my benefits continue if the Policy terminates?*			Optional module
		Conversion Right: *If my coverage under the Policy stops, do I have a right to conversion?*	1	may be deleted	Optional module
			2	may be deleted	
			3	may be 12-60 months or expressed in years	
			4	may be deleted if no limiting age	
			5	may be deleted if only one class	
			6	may be deleted if only one class	
			7	may be deleted	
		How do I Convert my Coverage?	1	may be 31-60 days	Optional module
NHCRTLTD-BEN 4/08		Benefits			
		Disability Benefit: *What are my Disability Benefits under The Policy?*		may be deleted	one of four Disability benefit modules will be used, all others optional
		Mental Illness And Substance Abuse Benefits: *Are benefits limited for Mental Illness[or Substance Abuse?]*	1	may be deleted	
			2	item may be deleted; items listed may be added to or deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			3	paragraph may be replaced by: Benefits will be payable: 1) for as long as you are confined in a hospital or other place licensed to provide medical care for the disabiling condition; or, 2) if not confined, or after you are discharged and still disabled, for a total of [24 months] for all such disabilities during your lifetime. OR Benefits will be payable only for so long as you are confined in a hospital or other place licensed to provide medical care for the disabiling condition.	
			4	24 months may be 12-60 months	
			5	24 months may be 12-60 months	
			6	may be 60-180 days	
			7	may be 7-30 days	
			8	may be 60-180 days	
			9	may be 7-30 days	
			10	may be 7-30 days	
		Substance Abuse Limitation: *Are benefits limited for alcoholism or Substance Abuse?*	1	may be deleted	
			2	Items listed may be added to or deleted	
			3	may be "up to 60 months"	
		Recurrent Disability: *What happens if I Recover but become Disabled again?*	1	may be "equal to" and 7-365 days may be stated	
			2	may be 3-9 months	
			3	may be 3-9 months	
		Calculation of Monthly Benefit: *How are my Disability benefits calculated [during the Initial Benefit Period]?*	1	may be deleted	
			2	may be deleted	
			3	may be deleted	
		Calculation of Monthly Benefit:Return to Work Incentive: *How are my Disability benefits calculated?*	1	may be 12-36 months or expressed in years	
			2	may be deleted	
			3	may be deleted	
			4	may be 60-100%	
			5	may be 12-60 months or expressed in years	
			6	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			7	may be deleted	
			8	may be deleted	
		Calculation of Monthly Benefit:*Return to Work Incentive: How are my Disability benefits calculated?*	1	may be 12-60 months or expressed in years	
			2	may be 60-100%	
			3	may be deleted	
			4	may be deleted	
		Calculation of Monthly/Weekly Benefit: What happens if the sum of [my Monthly Benefit, Current Monthly Earnings and Other Income Benefits] Exceeds 100 % of my Pre-disability Earnings?	1	Monthly Benefit may be added to Current Earnings and/or Other Income Benefits for the purpose of this provision.	
			2	statement may or may not be included depending on case specifics	
			3	statement may or may not be included depending on case specifics	
		Calculation of Monthly Benefit:Return to Work Incentive: *How are my Disability benefits calculated?*	1	may be 12-60 months or expressed in years	
			2	may be 60-100%	
			3	may be 12-60 months or expressed in years	
		Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*			
		Partial Month Payment: *How is the benefit calculated for a period of less than a month?*			
		Denial of Social Security Benefits: *After the Initial Benefit Period expires, is there any allowance if you are ineligible for Social Security?*			
NHCRTLTD-BEN-Term 4/08		Termination of Payment: *When will my benefit payments end?*	1	item may be deleted	
			2	may be deleted	
			3	may be deleted	
			4	may be deleted	
			5	may be deleted	
			6	may be deleted	
			7	may be 60-100%	
			8	may be deleted	
			9	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	
			13	may be deleted	
			14	each one of items a-d may be deleted or combined	
			15	may be deleted	
NHCRTLTD-BEN-FC/Cola 4/08		Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?*	1	may be age 10-26	
			2	may be 100-800	
			3	may be 6-12 months	
			4	may be $100-$400	
			5	may be $2500-$10,000	
			6	may be 12-36 months or expressed in years	
			7	may be 80-100%	
			8	may be deleted	
		Cost-Of-Living Adjustment: *How do my benefits keep abreast of inflation?*	1	may be "We may"	
			2	may be 12-36 months or expressed in years	
			3	item may be deleted	
			4	item may be deleted or % may be 20-50%	
			5	may be Policy Anniversary or some other date	
			6	may be 3-15%	
			7	may be 3/4 or deleted	
			8	may be deleted	
			9	may be 5 to unlimited	
			10	may name comparable CPI-W indicator or: "appproved by the Insurance Commissioner of the state in which the Policy is being delivered."	
NHCRTLTD-BEN-SurvInc 4/08		Survivor Income Benefit: Will my survivors receive a benefit if I die while receiving Disability Benefits?	1	the term "Disability" may be deleted depending on case specifics	optional module
			2	phrase may be deleted	
			3	may be 12-36 months or expressed in years and/or "or have met the Elimination Period" may be added	
			4	may be called something else or deleted or "benefit" may be substituted	
			5	statement may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			6	may be:[The Survivor Income Benefit will only be paid: 1) to Your Surviving Spouse; or 2) if no Surviving Spouse, in equal shares to Your Surviving Children.] If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.]	
			7	either 1) or 2) or both may be included or deleted	
			8	may be deleted	
			9	may be deleted	
			10	or may show actual dollar amount or may state: "The Survivor Income Benefit amount is shown in the Schedule"; or monthly benefit amount and maximum payment period language may be substituted	
			11	optional benefit amount may be shown here where "3" may be "3-12"	
			12	beneficiary language may be deleted	
			13	may be deleted	
			14	19 may be 19-26	
			15	may be deleted	
			16	entire option may be deleted	
			17	may be 6-12 months or an equivalent number of weeks	
			18	may include one statement or the other or both 1) and 2)	
			19	may be 6-12 months	
NHCRTLTD-BEN-ExtErn/Wrk 4/08		Extended Earnings Protection Benefit: *Will benefits continue to be paid after my return to Active Employment if my earnings are less than Pre -disability Earnings?*	1	may be deleted or "Part time" may be added or replace "Full time"	
			2	may be deleted	
			3	may be deleted	
			4	may be 60-80%	
			5	may be deleted	
			6	may be deleted	
			7	may be 3-24 months	
			8	may be 60-80%	
		Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*			
NHCRTLTD-BEN-PC/ICD 4/08		Pension Contribution Benefit: *Does this Policy also cover contributions to a Pension Policy?*	1	may be 1 year; may be 1-5 years or all items may be replaced with language to accommodate Policyholder request and practice	
			2	may be deleted and flat amount stated	
			3	may be 15-75%; entire list may be amended to meet the case specifications	
			4	may be $2,500-$10,000	

Form #	Module #	Description	Variable #	Description of Variables	Use
			5	may be 12-36 months or expressed in years or may be deleted	
		Infectious And Contagious Disease Benefit: *If it is disclosed that I carry an Infectious and Contagious Disease, will the Policy cover the income lost as the result of limitations placed on my license or reduced patronage?*	1	may be 6-36 months or expressed in years or may be 1-26 weeks	
			2	may be Benefit Commence period	
			3	may be 20-60%	
			4	may be replaced by the following: We will use the following calculation to determine Your [Weekly/Monthly] Benefit: Weekly/Monthly Benefit = (A – B) x C A Where A = Your Pre disability Weekly/Monthly Earnings. B = Your Current Weekly/Monthly Earnings. C = The [Weekly/Monthly Benefit] payable if You were Totally Disabled.]	
			5	may be deleted	
			6	may be deleted	
			7	may be 40-80%	
			8	may be deleted or some other determinate may be listed	
			9	may be either table or payable	
			10	may be deleted	
			11	may be 1-5 years or 1-26 weeks	
NHCRTLTD-BEN-ADL 4/08		Activities of Daily Living Benefit: *What is the Activities of Daily Living Benefit?*	1	may be 2-4	
			2	either item may be deleted	
			3	may be 30-90 days	
			4	flat benefit amount may be stated here or % may be 10-40; monthly may be revised to meet specifications of the case	
			5	$5,000 may be $5,000 - $15,000	
			6	may be deleted	
			7	may be 1 - 10 years	
			8	may be deleted	
			9	may be deleted	
			10	may be 2-5	
			11	may be deleted or maximum shown here	

Form #	Module #	Description	Variable #	Description of Variables	Use
NHCRTLTD-BEN--AD 4/08		Accidental Dismemberment and Loss of Sight Benefit: *What benefits are payable for dismemberment or loss of sight due to an accidental bodily injury?*	1	may be 90-365 days	
			2	items may be added to loss table	
			3	items will correspond to loss table	
NHCRTLTD-BEN-BsProt 4/08		Business Protection Benefit: *Are additional Disability Benefits paid to compensate for business revenue lost when I am Disabled?*	1	may be 90-365 days	
			2	may be edited to reflect case specifics	
			3	may be 15%-25%	
			4	may be "Monthly Income Loss"	
			5	may be $2,500-$5,000	
			6	may be deleted	
			7	items in list may be deleted to, amended or added to or last item deleted	
			8	may be 12-36	
		Cafeteria Plan Election Restriction			
		[Rehabilitation Bonus: What happens if I successfully com;plete an approved program of Rehabilitation?	1	entire module may or may not be included	optional module
			2	May be 1-12 times the Monthly Benefit	
NHCRTLTD-EXCL 4/08		Exclusions and Limitations			
		Exclusions: What Disabilities are not covered?	1	items in this list may be deleted	optional module
			2	phrase may be deleted	
			3	may be deleted	
			4	may be "accidental bodily injury" and "sickness" if LTD	
			5	may be "accidental bodily injury" and "sickness" if LTD	
			6	may be any or another	
		Pre-Existing Condition Limitation: *Are benefits limited for Pre -existing Conditions?*	1	may be: We will pay benefits, or an increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition for a limited number of days as shown in the Schedule.	Optional module
			2	may be deleted	
			3	may be 90-365 days; 3-12 months	
			4	may be deleted	
			5	may be 90-365 days; 3-12 months	
			6	may be deleted	
			7	may be deleted	

Form #	Module #	Description	Variable #	Description of Variables	Use
			8	may be 30-730 days; 1-24 months	
NHCRTLTD-Prov 4/08		GENERAL PROVISIONS			
		Notice of Claim: *When should I notify the Company of a claim?*	1	may be deleted	Always included
			2	"written" may be deleted or may be "written, electronic or telephonic" or any variation thereof	
			3	may be 15-90 days	
			4	may be deleted	
			5	may be deleted	
			6	may be 15-90 days	
		Claim Forms: *Are special forms required to file a claim?*	1	may be deleted	Always included
			2	may be 15-45 days	
			3	may be 15-45 days	
			4	"written" may be deleted or may be "written, electronic or telephonic" or any variation thereof	
			5	may be deleted	
			6	may be 15 - 45 days	
		Proof of Loss: *What is Proof of Loss?*	1	list may be added to or items may be deleted	Always included
		Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*			Optional module
		Sending Proof of Loss: *When must proof of Loss be given?*	1	may be 90-180 days	Always included
			2	may be 1-2 years	
			3	may be 30-90 days	
		Claim Payment: *When are benefit payments issued?*	1	may be "immediately"	Either H06 or H07 will be used
		Claims to be Paid: *To whom will my claim be paid?*	1	may be $1,000 - $7,000	Always included
		Claim Denial: *What notification will I receive if my claim is denied*			Always included
		Claim Appeal: *What recourse do I have if my claim is denied?*	1	may be 180-365 days	Always included
			2	may be 60-180 days	
		Social Security: *When must I apply for Social Security Benefits?*	1	may be 30-180 days	Optional module

Form #	Module #	Description	Variable #	Description of Variables	Use
		Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*			Optional module
		Overpayment: *When does an overpayment occur?*	1	items in list may be added to or deleted	Optional module
		Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*	1	may be 30-90 days	Optional module
			2	items in list may be added to or deleted	
			3	may be deleted	
		Subrogation: *What are the Company's subrogation rights?*	1	definition of "Third Party" may be included in next provision if this provision deleted.	Optional module
		Reimbursement: *What are the Company's Reimbursement Rights?*			Optional module
		Legal Actions: *When can legal action be taken?*	1	may be 60-180 days	Always included
			2	may be 3-6 years	
			3	may be deleted	
		Fraud: *How does the Company deal with fraud?*	1	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	Always included
			2	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	
			3	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	
		Misstatements: *What happens if facts are misstated?*	1	may be deleted; or "except fradulent misstatements" may be added	Always included
		Policy Interpretation: *Who interprets Policy terms and conditions?*			Optional module
NHCRTLTD-RID 4/08		Rider Language	1	rider language may be attached to any benefit or provision herein in order to provide additional or optional benefits or provisions after the certificate is issued; may also be used to amend variable language in certificate after issue.	Optional module
			2	Policyholder name and Policy number may be stated	
			3	may be "certain" certificates	
			4	actual effective date may be stated here	
			5	may be deleted	
			6	signatures will change if officers change	

INSURER INFORMATION NOTICE

Any questions regarding The Policy may be directed to:

National Guardian Life Insurance Company
P.O. Box 98100
Baton Rouge, LA 70898

Phone: 888-729-5433
Fax: 888-729-7827

If the question is not resolved, the Arkansas Insurance Department may be contacted at:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street, Room 340
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

This notice is for information only and does not become a condition of The Policy.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
2 East Gilman Street Madison, Wisconsin 53701

[Policyholder: ABC Policyholder] **1**
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE] **[Participating Entity]**
[Policy Anniversary Date: DATE] **[Account Number: XXXXXXX]**

Administrator: [Insert Administrator Name
Insert Administrator Address] **2**

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

[Sherri Kliczak, Secretary John Larson, President] **3**

[SHORT TERM DISABILITY COVERAGE] **4**

[**READ YOUR CERTIFICATE CAREFULLY**

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.] **5**

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

6

[**Table of Contents**

Schedule of Insurance

[The Policy of short term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You**. **1**

The benefits described herein are those in effect as of DATE.

Cost of Coverage:
Option 1 - You do not contribute toward the cost of coverage under Option 1.

Option 2 - You must contribute toward the cost of coverage under Option 2.

Eligible Class(es) For Coverage:
All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least # hours weekly

Weekly Benefit: The lesser of:
1) Option 1: [X% of Your Pre-disability Earnings/an amount you elect in increments of $X;]
2) Option 2: [X% of Your Pre-disability Earnings/an amount you elect in increments of $X]; or
3) $XX.

The Weekly Benefit will be rounded to the next higher $10.00/$1.00 if not already such a multiple.

Minimum Weekly Benefit: $XXX
In accordance with Arkansas state law, in no event will the Minimum Weekly Benefit be less than $12.50.

Maximum Duration of Benefits Payable:
1) if Your Disability is the result of a Pre-existing Condition: # days if caused by Injury or Sickness; otherwise
2) # weeks if caused by Injury or Sickness

Benefits Commence::
1) for Disability caused by Injury: on the 1st consecutive day of Total Disability or Disabled and Working;
2) for Disability caused by Sickness: on the 8th consecutive day of Total Disability or Disabled and Working
3) with the exception of benefits required by state law, the expiration of any Employer sponsored salary continuation program.

For hospital confinements of 24 hours or more, or for an Outpatient Surgical Procedure which necessitates a Total Disability period or a Disabled and Working Disability period of 24 hours or more after surgery, benefits commence:
1) on the first day of hospital confinement; or
2) on the date of the Outpatient Surgical Procedure.

Annual Enrollment Period: From month & day through month & day

Eligibility Waiting Period for Coverage
1) XX days - if You are Actively at Work for the Employer on the Policy Effective Date; or
2) XX days - if You start working for the Employer after the Policy Effective Date.

The number of days referenced above are continuous calendar days. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time/Part-time/temporary Active Employee with the Employer under the Prior Policy.]

Definitions

[Actively at Work means at work with [the Employer] on a day that is one of [the Employer's] scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and — 1
2) for [Your usual number of hours.] — 2

[We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.]

Active [Employee] means [an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.] — 1

Any Occupation means any occupation for which You are qualified by education, training or experience, [and that has an earnings potential greater than the lesser of: — 1

1) [the product of Your Indexed Pre-disability Earnings and the Initial Benefit Period Percentage]; or — 2, 3
2) [the Maximum Weekly Benefit.]]

Bonuses means the [weekly average of monetary] bonuses You received from [the Employer] [over: — 1,2,3

1) the [X month] period ending [immediately prior to the date] You became Disabled; or — 4,5
2) the period of time You worked for [the Employer,] if shorter than [the above period/X months.]] — 6

Commissions means the [weekly average of monetary] commissions You received from [the Employer] [over: — 1,2,3

1) the [X month] period ending [immediately prior to the date] You became Disabled; or — 4,5
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]] — 6

[Current [Monthly/Weekly] Earnings means [Monthly/Weekly] earnings You receive from:

1) [the Employer; and — 1
2) other employment;]

while You are Disabled [and eligible for the Disabled and Working Benefit.] — 2

[However, if the other employment is a job You held in addition to Your job with the Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceed Your average earnings from the other employer over the [6 month] period just before You became Disabled will count as Current [Monthly/Weekly] Earnings.] — 3, 4, 5

[Current [Monthly/Weekly] Earnings also includes the pay You could have received for another job or a modified job if:

1) such job was offered to You by the Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.]

Definitions

Disabled and Working

means that You [or Your Spouse] are prevented by: 1

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy] 2

from performing some, but not all of the Essential Duties of Your [or his or her] Occupation, are working on a part-time or limited duty basis [before age 70] [and, as a result, Your [or Your Spouse's] Current [Weekly] Earnings are more than [20]%, but are less than or equal to [80]% of Your [or Your Spouse's] Pre-disability Earnings.] 3,4 5,6,7

Disability or Disabled

means Total Disability [or Disabled and Working Disability]. 1

Employer

means the [Policyholder]. 1

Essential Duty

means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. [However, working more than [X] hours per week is not an Essential Duty.] 1

Injury

means bodily injury resulting:

1) directly from accident; and
2) independently of all other causes;

[which occurs while You are covered under The Policy.] [However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.] 1,2

Mental Illness

means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
Mental Retardation;

1) Pervasive Developmental Disorders;
2) Motor Skills Disorder;
3) Substance-Related Disorders;
4) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
5) Narcolepsy and Sleep Disorders related to a General Medical Condition.

[Other Income Benefits

means the amount of any benefit for loss of income, provided to You [or to Your family], as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You [or Your family] are eligible or that are paid to You, [to Your family] or to a third party on Your behalf, pursuant to any:

1) [temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
3) plan or arrangement of coverage, [other than income from any accumulated sick time, salary continuation or paid time off,] whether insured or not, which is received from the Employer as a result of employment by or association with the Employer or which is the result of membership in or association with any group, association, union or other organization;
4) [any income You received from the Employer as a result of any accumulated sick time salary continuation or paid time off, which causes the Weekly Benefit, plus Other Income Benefits to exceed [X%] of Your Weekly Earnings. The amount in excess of [X%] of Your Weekly Earnings will be used to reduce the Weekly Benefit.]
5) [individual insurance policy where the premium is wholly or partially paid by the Employer;]
6) [mandatory "no-fault" automobile insurance plan;]
7) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, [Your spouse and/or children,] are eligible to receive because of Your Disability; or
8) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under the Employer's Retirement plan;
2) [temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;]
3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your [after-tax] contributions.); or
5) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
   d) similar plan or act;

   that You, [Your spouse and children] receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

[If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of: 15

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, [and the time period to be 24 months.] We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim. 16

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.]

Outpatient Surgical Procedure means a medically necessary surgical procedure performed by a Physician in the outpatient department of a hospital or ambulatory surgical center.

Participating [Employer] means [an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.] 1

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

[Pre-disability Earnings means, [for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation]: 1

1) the [weekly] average of earnings reported as "net earnings from self-employment" for federal income tax purposes for: 2
   a) the [X tax] year(s) just prior to the date of Disability; or 3
   b) the number of months You were employed in this capacity, if less than above period; and 4
2) [not] contributions You make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section125 plan,

   for the same period as above. 5,6

Pre-disability Earnings [does not include] [bonuses, commissions, tips and tokens,] dividends, capital gains and returns of capital.

Pre-disability Earnings means, [for specific class description if applicable] Your average [weekly] rate of pay, [including Bonuses, Commissions and Tips and Tokens], from the Employer for the [X] calendar year(s) ending immediately before the date You become Disabled, or over the number of calendar months of employment, if less than this period: 1,2 3, 4

1) [not] including contributions you make through a salary reduction agreement with the Employer to: 5
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions, tips and tokens] overtime pay or expense reimbursements for the same period as above. 6,7

Definitions

Pre-disability Earnings

means, [for specific class description if applicable], Your regular [weekly] rate of pay, including [Bonuses, Commissions and Tips and Tokens], 1,2 3 4

1) [not] including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or 5,6
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2) [not] including [bonuses, commissions and tips and tokens] overtime pay or expense reimbursements for the same period as above.]

[Prior Policy

means the [long term disability insurance] carried by [the Employer] on the day before the [Policy] Effective Date. 1,2

Regular Care of a Physician

means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitative Employment

means employment or service which:

1) prepares a Disabled person to resume gainful work; and
2) is approved, in writing, by Us.

Related

means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild [or similar relationship in law].] 1

[Retirement Plan

means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) [a profit sharing plan; 1
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.]

Sickness

means a Disability [or loss] which is: 1

1) caused or contributed to by:
   a) any condition, illness, disease or disorder of the body;
   b) any infection, except a pus-forming infection of an accidental cut or wound [or bacterial infection resulting from an accidental ingestion of a contaminated substance]; 2
   c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Policy; or 3
   d) [pregnancy;] 4

caused or contributed to by any medical [or surgical] treatment for a condition shown in item 1) above.

Definitions

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

[Substance includes alcohol and drugs but excludes tobacco and caffeine.] 1

The Policy means the policy which We issued to [The Policyholder under the policy number] shown on the face page. 1

Tips [and Tokens] means the [weekly average of monetary] tips and tokens You received from [the Employer] [over: 1,2,3

1) the [X month] period ending [immediately prior to the date] You became Disabled; or 4,5
2) the period of time You worked for [the Employer], if shorter than [the above period/X months.]] 6

Total Disability or Totally Disabled means that You are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;] 1

from performing the Essential Duties of Your Occupation,[and as a result, You are earning 20% or less of Your Pre-Disability Earnings.] 2

Trust means [the trust fund established by XXX.] 1

We, Our, or Us means [the insurance company named on the face page of The Policy.] 1

[Weekly] Benefit means a [weekly] sum payable to You while You are Disabled, subject to the terms of The Policy. 1, 2
[Your Benefit will be paid according to the [9] month pay schedule established by Your employment contract in effect immediately prior to the date of Your Disability.] 3

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

[If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.] 1

[If You are an attorney, Your Occupation means the legal specialty or specialties in which You have practiced in the five year period preceding Your becoming Disabled. If You have been in legal practice for less than five years, Your Occupation means the legal specialty or specialties in which You have practiced in the period preceding Your Disability.] 2

You or Your means the person to whom this certificate is issued.]

Eligibility and Enrollment

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:

1) the [Policy] Effective Date ; [or
2) the date on which You complete the Eligibility Waiting Period for Coverage. 1

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.]

Enrollment: *How do I enroll for coverage?*

[For coverage under Option 1, all eligible Active Employees will be enrolled automatically by the Employer. 1

For coverage under Option 2, You must enroll.] To enroll [for coverage]You must: 2

1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.] 3

[If You do not enroll within [31 days] after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:] 4, 5

1) You must give Us Evidence of Insurability satisfactory to Us; and
2) [You may only enroll: 6
   a) during an [Annual Enrollment Period] designated by the Policyholder; or 7
   b) within [31 days] of the date You have a Change in Family Status.] 8

[The dates of the [Annual Enrollment Period] are shown in the Schedule of Insurance.] 9

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability may include, but will not be limited to:

1) [a completed and signed application approved by Us; 1
2) a medical examination; and
3) any additional information and attending Physicians' statements.]

All Evidence of Insurability will be furnished at [Your] expense. We will then determine if You are insurable under The Policy. 2

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

1) [You get married or You execute a domestic partner affidavit; 1
2) Your child is born or You adopt or become the legal guardian of a child;
3) Your spouse dies or You and Your spouse divorce;
4) Your child is emancipated or dies;
5) Your spouse is no longer employed, which results in a loss of group insurance; or
6) You have a change in classification from part-time to full-time or from full-time to part-time.]

Period of Coverage

Effective Date: *When does my coverage start?*

[If You are not required to contribute toward The Policy's cost,] Your coverage will start: 1

1) [for benefit amounts not requiring Evidence of Insurability,] on the date You become eligible; or 2 3
2) [for benefit amounts requiring Evidence of Insurability, on the date We approve such evidence.] 4 5,6

[If You must contribute toward The Policy's cost,] Your coverage will start on the earliest of:

1) [the date] You become eligible, [for benefit amounts not requiring Evidence of Insurability,] if You enroll or have enrolled by then; 7,8 9
2) [the date] on which You enroll, [for benefit amounts not requiring Evidence of Insurability,] if You do so within [31 days] after the date You are eligible; 10,11
3) [[the date] We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability; or] 12,13
4) [the first day of the month following the Annual Enrollment Period if You enroll, [for benefit amounts not requiring Evidence of Insurability,] during an Annual Enrollment Period.]

Deferred Effective Date: *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:

1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) [pregnancy;] 1

on the date Your insurance [or increase in coverage] would otherwise have become effective, Your insurance, [or increase in coverage] will not become effective until You are Actively at Work one full day. 2 3

[Changes in Coverage: *Can I change my benefit option?*

[You may change Your benefit option only:
1) during an Annual Enrollment Period; or
2) within [31 days] of a Change in Family Status.

At such time] You may decrease coverage, or increase coverage to a higher option. [An increase in coverage [that is greater than the next higher option from Your current coverage] will be subject to Your submission of an application that meets Our approval.]]

[When will a requested change in benefit option take effect?

[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:
1) [the first day of the month following the Annual Enrollment Period;] or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the later of:
1) the date You enroll for the change; or
2) [the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.]]

[Any such increase in coverage is subject to the following provisions:
1) Deferred Effective Date; and
2) Pre-existing Conditions Limitations.]]

Do coverage amounts change if there is a change in [my class or] my rate of pay?

Your coverage may increase or decrease on the date there is a change in [Your class or] Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes the Policy?

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, [subject to the following provisions:
1) the Deferred Effective Date provision; and

Pre-existing Conditions Limitations.]

Period of Coverage

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*

[If You were: 1
1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the [Policy] Effective Date, the Deferred Effective Date provision will not apply.]

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

[If You become insured under The Policy on the [Policy] Effective Date and were covered under the Prior Policy on the day before the [Policy] Effective Date, the Pre-existing Conditions Limitation will end on the earliest of : 2

1) the [Policy] Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

[The amount of the [Weekly] Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of: 3,4

1) the [Weekly] Benefit which was paid by the Prior Policy; or 5
2) the [Weekly] Benefit provided by The Policy.] 6

The Pre-existing Conditions Limitation will apply after the [Policy] Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.]

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received [weekly] benefits for disability under the Prior Policy, and You returned to work as a [Full-time] Active Employee [before The [Policy] Effective Date], then, if within [6 months] of Your return to work: 7 8,9,10

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination: *When will my coverage stop?*

Your coverage will end on the earliest of the following:

1) [the date] The Policy terminates; 1
2) [[the date] The Policy no longer insures Your class;] 2,3
3) [the date] premium payment is due but not paid by the Employer; 4
4) [the last day of the period for which You make any required premium contribution;] 5
5) [the last day of the month on or next following the month in which Your Employer terminates Your employment;] 6
6) [the date] You cease to be a [Full-time] Active Employee in an eligible class for any reason, unless coverage is extended under the Continuation Provisions; or 7,8
7) [the date Your Employer ceases to be a Participating Employer]. 9

Period of Coverage

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium [by the Employer;] and
3) terminates when the Policy terminates, [coverage for Your class terminates or Your Employer ceases to be a Participating Employer.]

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

[Leave of Absence: If You are on a documented [medical] leave of absence, other than Family or Medical Leave, Your coverage may be continued [until the last day of the month in which] the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued [until the last day of the month in which] the lay-off commenced. If the lay-off becomes permanent, this continuation will cease immediately.]

[Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to [12 weeks, or longer if required by other applicable law,] following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.]

[General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage [until the last day of the month in which] the coverage terminated. If the work stoppage ends, this continuation will cease immediately.]

[Sabbatical: If You are on a documented [paid] sabbatical, Your coverage may be continued [until the last day of the month in which] the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.]

[Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to [8 weeks]. [If the leave ends prior to the agreed upon date, this continuation will cease immediately.]]

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*

[If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive [short term] Disability Benefits provided premiums for Your coverage continue to be paid.

After [short term] Disability benefit payments have ceased, Your insurance will be reinstated, provided:

1) You return to work for one full day as a [Full-time] Active Employee in an eligible class;
2) The Policy remains in force; and
3) the premiums for You were paid during Your Disability, and continue to be paid.]

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Disability Benefit: *When do I qualify for Disability Benefits?*

If, while covered under this Benefit, You:

1) become Totally Disabled;
2) remain Totally Disabled; and
3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

[The amount of any Weekly Benefit payable will be reduced by:

1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and 1
2) any income received from [the Employer] for the period You are Totally Disabled.] 2

[Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*

Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.] 3

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay [1/7] of the Weekly Benefit for each day You were Disabled. 4

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*

When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within [14] consecutive [calendar] days of the return to work; 1, 2

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for [14] consecutive days or more, any recurrence of a Disability will be treated as a new Disability. 3

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions [and Pre-existing Conditions Limitations] will apply to the new cause of Disability. 1

Termination of Benefit Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) [the date You are no longer under the Regular Care of a Physician, [unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to You;]] 1,2 3
4) [the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;]
5) the date of Your death;
6) [the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;] 4
7) [the last day benefits are payable according to the Maximum Duration of Benefits; 5
8) [the date Your Current Monthly/Weekly Earnings are equal to or greater than [80 %] of Your [Indexed] Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;] or 6,7,8
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration;] or 9, 10
10) [the date You refuse to participate in a Rehabilitation program, [or refuse to cooperate with or try: 11
    a) modifications made to the work site ro job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;] 12
    b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation [or a Reasonable Alternative;]] or 13
11) [the date You receive retirement benefits from any employer's Retirement plan, unless:
    a) You were receiving them prior to becoming Disabled; or
    b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.]

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [We will use the following calculation to determine Your [or Your Spouse's] [Weekly/Monthly] Benefit: 1

[Weekly/Monthly] Benefit = (A – B) x C
A

Where
A = Your Pre-disability [Weekly/Monthly] Earnings.
B = Your Current [Weekly/Monthly] Earnings.
C = The [Weekly/Monthly Benefit] payable if You were Totally Disabled.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.] 2

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [the Weekly/Monthly Benefit] otherwise payable for Total Disability will be reduced by [%] of Your Current 1
[Weekly/Monthly] Earnings. Your [Weekly/Monthly Benefit], however, will not be less [than the 2
Minimum Weekly/Monthly Benefit.]

If You are participating in a program of Rehabilitative Employment approved by Us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.] 3

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*

If, while covered under this benefit, You are Disabled and Working, as defined, [and payments under the Total Disability benefit under The Policy have begun, the following calculation will be used to determine Your [Weekly/Monthly Benefit]: 1

1) multiply Your Pre-Disability Earnings by the Benefit Percentage; and
2) compare the result with the Maximum Benefit; and
3) from the lesser amount deduct Other Income Benefits.

Current Weekly/Monthly Earnings will not be used to reduce Your [Weekly/Monthly] Benefit. However, if the sum of Your Weekly/Monthly Benefit and Your Current [Weekly/Monthly] Earnings exceeds [80% of] Your Pre-Disability Earnings, We will reduce Your [Weekly/Monthly] Benefit by the amount of the excess.] 2

If You are participating in a program of Rehabilitative Employment approved by us, We will determine Your [Weekly/Monthly Benefit] by the Rehabilitative Employment Benefit.

[Days which You are Disabled and Working may be used to satisfy the Benefits Commence/Elimination Period.] 3

Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*

If, while You are Totally Disabled [or Disabled and Working], You accept Rehabilitative Employment, We will continue to pay a [Weekly/Monthly] Benefit. 1

The [Weekly/Monthly] Benefit We will pay will be equal to Your Total Disability [Weekly/Monthly] Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the [Weekly/Monthly] Benefit and total income received from Rehabilitative Employment may not exceed [100%] of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the [Weekly/Monthly] Benefit paid by Us will be reduced by the excess amount. 2

We reserve the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Policy.

If You remain Totally Disabled [or Disabled and Working] after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit [or Disabled and Working], subject to the Maximum Payment Period for such benefit.

OPTIONAL

Cost-Of-Living Adjustment:

How do my benefits keep pace with inflation?

We [will] adjust Your Weekly Benefit for increases in the cost-of-living if:

1) You have been Disabled for [12 consecutive months]; and
2) [You are receiving benefits;] [and
3) Your Current Weekly Earnings are less than or equal to 20% of Your Pre-disability Earnings;]

when the Cost-of-Living Adjustment is made. We make the Cost-of-Living Adjustment [each year on January 1st.]

What is the Cost-of-Living Adjustment formula?

We apply the Cost-of-Living Adjustment formula by:

1) determining the lesser of:
   a) [%]; or
   b) [1/2] the percentage change in the Consumer Price Index;
2) multiplying the resulting percentage (%) times the Weekly Benefit for Disability being received; and
3) adding the resulting amount to Your Weekly Benefit.

When will the Cost-of-Living Adjustments end?

You will not receive a Cost-of-Living Adjustment after:

1) You cease to be Disabled; [or
2) You have received [5] adjustments;] or
3) The Policy terminates.

Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is [comparable to the CPI-W / approved by the Insurance Commissioner of the state in which the Policy is delivered].

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W.

Cafeteria Plan Election Restriction

The Policy is a part of a Cafeteria Plan sponsored by Your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

Cafeteria Plans are subject to the following restriction:
The benefits You elect during the enrollment period will remain in effect until the next enrollment period.

Section 125 allows exception to this rule only in specified situations, including Change in Family Status and commencement or termination of employment.

Exclusions and Limitations

Exclusions: *What Disabilities are not covered?*

[The Policy does not cover, and We will not pay a benefit for any Disability: 1

1) unless You are under the Regular Care of a Physician;
2) that is caused [or contributed to by] war or act of war (declared or not); 2
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused [or contributed to by] an intentionally self-inflicted [Injury]; 3,4
6) unless it is the result of a work-related [Injury or Sickness] sustained in the course of performing tasks for the Employer; 5
7) for which Workers' Compensation benefits are paid, or may be paid, if duly claimed; or
8) sustained as a result of doing any work for pay or profit for [any/another] employer, including self-employment.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy,

no benefits will be payable for the Disability under The Policy.]

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

[We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that 1
results from, or is caused or contributed to by, a Pre-existing Condition,] [unless, at the time You 2
become Disabled:

1) You have not received Medical Care for the condition for [365] consecutive day(s)] while insured under The Policy; or 3
2) [You have been continuously insured under The Policy for [365] consecutive day(s)]. 4,5

Pre-existing Condition means:

1) any [accidental bodily injury, sickness,] Mental Illness, pregnancy, or episode of Substance Abuse; or 6
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such [accidental bodily injury, sickness,] Mental Illness, pregnancy, or Substance Abuse; 7

for which You received Medical Care during the [730] day period that ends the day before: 8

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us, [or Our representative,] [written] notice of a claim within [30 days] after Disability [or loss] occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number. 1,2,3

[If You are Disabled and become eligible for the Activities of Daily Living Benefit, You must file a separate Notice of Claim within [30 days] of becoming eligible.] 4 5

Claim Forms: *Are special forms required to file a claim?*

We [or Our representative] will send forms to You to provide Proof of Loss, within [15 days] of receiving a Notice of Claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim. 1, 2 3,4

[Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.] 5

Proof of Loss: *What is Proof of Loss?*

[Proof of Loss may include but is not limited to the following: 1

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current [Monthly/Weekly] Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis.]
All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits **if You refuse to be examined or meet to be interviewed by Our representative.**

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within [90 days] after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if: 1

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than [1 year] after it is due, unless You are not legally competent. 2

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within [30 days] of the request. 3

Claim Payment: *When are benefit payments issued?*

When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid [as soon as] Proof of Loss satisfactory to Us is received. 1

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

Claims to be Paid: *To whom will benefits for my claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to [$1,000] to a person who is Related to You and who, at Our sole discretion, is **entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.** 1

Claim Denial: *What notification will I receive if my claim is denied*

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

1) You must request a review upon written application within:
   a) [180 days] of receipt of claim denial if the claim requires Us to make a determination of disability; or 1
   b) [60 days] of receipt of claim denial if the claim does not require Us to make a determination of disability; and 2
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

[Social Security: *When must I apply for Social Security Benefits?*

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within [45 days] from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required: 1

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.]

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We reserve the right to reduce Your [Monthly/Weekly] Benefit by estimating the Social Security disability benefits You [or Your spouse and children] may be eligible to receive.

When We determine that You [or Your Dependent] may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your [Monthly/Weekly] Benefit by the estimated amount. Your [Monthly/Weekly] Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your [Monthly/Weekly] Benefit by an estimated amount and:

1) You [or Your Dependent] are later awarded Social Security disability benefits, We will adjust Your [Monthly/Weekly] Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your [Monthly/Weekly] Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your [Monthly/Weekly] Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision .

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) [retroactive awards received from sources listed in the Other Income Benefits definition; 1
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.]

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.] 1

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) [You; 2
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate.]
2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum [Monthly/Weekly] Benefit,] until full reimbursement is made. Payments may continue when the overpayment has been recovered; 3
3) refer Your unpaid balance to a collection agency; and

pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You: 1

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Reimbursement: *What are the Company's Reimbursement Rights?*

We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

a) a legal judgment;
b) an arbitration award; or
c) a settlement or otherwise;

You must reimburse Us for the lesser of:

a) the amount of payment made or required to be made by Us; or

the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than [60 days] after the date proof of loss is given; or 1
2) [3] years after the date [Written] Proof of Loss is required to be given according to the terms of The Policy. 2,3

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You [and/or Your Employer] provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You [and/or Your Employer] commit Insurance Fraud. 1 2
We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You [and/or Your Employer] perpetrate Insurance Fraud. 3

General Provisions

Misstatements:
What happens if facts are misstated?

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

[No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.] 1

Policy Interpretation:
Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

[Rider Language This rider forms a part of [The Policy to which it is attached] and [all] certificates given in connection with 1, 2, 3
The Policy.

This rider becomes effective [on the later to occur of: 4

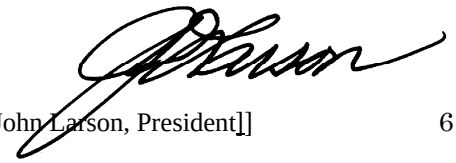
a) the effective date of the Policy or certificate to which this rider is attached; or
b) the first day of the month on or next following the date e accept Your application and required premium.]

[In consideration of the required additional premium and submission of satisfactory evidence of insurability, the following 5
benefit is added to The Policy and certificates:]

In all other respects, The Policy and certificates remain the same.

Signed for **National Guardian Life Insurance Company**
[

[



Sherri Kliczak, Secretary John Larson, President]] 6

ARKANSAS Statement of Variable Language

Group Short Term Disability Income Insurance

NHCRTSTD 4/08

Introduction: This statement of variable material (SOVL) shows the language we intend to substitute, delete or change. Variable language is identified by brackets ([ ]) in each module of Form(s) NHCRTGTL 4/08 et al. Each module is identified in this SOVL and each variable within each module is numbered on the form. These numbers directly correspond with the numbers on the SOVL for the appropriate module.

Constant Variables	
1	Wherever the term "the Employer" appears, it may be changed to "Your employer" or some other term to accommodate non-Employer groups
2	Wherever the term "Employee" appears, it may be changed to "Member" or "Associate" or some other term, to reflect the case specifics
3	Wherever the term "Policyholder" appears, it may be changed to "Employer" or "Organization" or some other term to reflect the case specifics
4	Wherever "Monthly/Weekly" appears, one or the other term will be used, not both, to reflect the case specifics
5	Wherever a reference to "Your Spouse" appears, it may be deleted if Spouse Disability coverage not offered; if that is the case, all other references will agree with no spouse coverage offered (eg. he or she deleted)
6	Wherever the word "Policy" appears, it may be replaced by "Plan" or some other term to accommodate the structure of the Policyholder
7	National Guardian Life Insurance Company may be National Guardian

Page #	Module #	Description	Variable #	Description of Variables	Use
NHCRTSTD 4/08		Face page	1	Fill-in information will vary by Policyholder; fill-in items may be deleted in whole or in part and may be located on Schedule of Insurance	Employer/non-Employer Market
			2	Included when administrator involved; fill-in information will vary dependent on the specific administrator	
			3	signatures will change if officers change	
			4	may be some other description of coverage, or may be deleted	
			5	may be in or out; 30 days may be 45, 60, 90 or 180	
			6	table of contents may be expanded and detailed and may appear on next page or a separate page	
NHCRTSTD-SCH (AR) 04/08		Schedule of Insurance		language on page is illustrative	STD - Employer Market
NHCRTSTD-DEF 04/08		Definitions		Note: Defintions may be deleted in their entirety if not applicable and/or placement in certificate may change	
		Actively at Work	1	actual number of hours may be stated here	Each definition may be used or deleted; variability indicated within each module
			2	paragraph may be deleted; specific items may be deleted or amended to meet the case specifics.	
		Active [Employee]	1	description may be revised to meet the case specifics; Employee may be Member or Associates or some other term to reflect the case specifics	
		Any Occupation	1	clause and items 1 and 2 may be deleted	
			2	may be: 40-100% of Your Indexed Pre-disability Earnings	
			3	Maximum Monthly Benefit may be shown here	
		Bonuses	1	clause may be deleted or "monetary" may be deleted	
			2	may be "Your Employer"	

Page #	Module #	Description	Variable #	Description of Variables	Use
			3	clause and items 1 and 2 may be deleted	
			4	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			5	may be actual date	
			6	may be specific period noted above	
		Commissions	1	clause may be deleted or "monetary" may be deleted	
			2	may be "Your Employer"	
			3	clause and items 1 and 2 may be deleted	
			4	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			5	may be actual date	
			6	may be specific period noted above	
		Current Monthly/Weekly Earnings	1	may show other source of income, eg: "Your law practice" etc…	
			2	may be deleted	
			3	may be deleted	
			4	may be 6-24 months	
			5	may be deleted	
		Disabled and Working	1	may be deleted	
			2	may be deleted	
			3	may state "Policy Age Limit", may be 70 - 90	
			4	entire clause may be deleted;	
			5	may be "monthly"	
			6	may be 20-50%	
			7	may be 80-100%	
		Disability or Disabled	1	clause may be deleted	
		Employer	1	may be Participating Employer or some other description, or Employer will be named	
		Essential Duty	1	number of hours will be shown - will be 20-80; or sentence deleted	
		Injury	1	may be deleted; or "within 30-365 days" may be added	
			2	may be deleted	
		Mental Illness			
		Other Income Benefits - definition continued		Note: the following definition of Other Income Benefits shows what we intend to use as a determination of other income benefits - for most Policyholders. However, we reserve the right to amend, alter or revise these definitions to reflect the nature of the Policyholder and/or accommodate his or her request	
			1	may be deleted	
			2	may be deleted	
			3	may be deleted	
			4	may be deleted	
			5	may be deleted	
			6	may be deleted	

Page #	Module #	Description	Variable #	Description of Variables	Use
			7	may be 80-100%	
			8	may be 80-100%	
			9	may be deleted	
			10	may be deleted	
			11	may be deleted	
			12	may be deleted	
			13	may be deleted	
			14	may be deleted	
			15	may be deleted	
			16	may be deleted or may be 12 to 60 months	
		Outpatient Surgical Procedure			
		Participating [Employer]	1	description may be revised to meet the case specifics and to describe the participating entity.	
		Physician			
		Pre-disability Earnings	1	items from this list may be deleted to correspond with Policyholder composition	
			2	monthly may be annual or weekly	
			3	number will be 1 to 10 or "tax" may be deleted	
			4	may be deleted	
			5	may be deleted	
			6	any from this list may be deleted or other items may be added to reflect the case specifics	
		Pre-disability Earnings	1	description of class will be shown or reference deleted	
			2	monthly may be annual or weekly	
			3	any from this list may be deleted or other items may be added to reflect the case specifics	
			4	number will be 1 to 10	
			5	may be deleted	
			6	may be deleted	
			7	any from this list may be deleted or other items may be added to reflect the case specifics	
		Pre-disability Earnings	1	description of class will be shown or reference deleted	
			2	may be deleted	
			3	any from this list may be deleted or other items may be added to reflect the case specifics	
			4	may be deleted	
			5	may be deleted	
			6	any from this list may be deleted or other items may be added to reflect the case specifics	
		Prior Policy	1	actual policy and insurance carrier may be stated here; may say "short term"; in any case, this will be an accurate description of the Prior Policy	
			2	name of Employer/Policyholder may be stated here	
		Regular Care of a Physician			

Page #	Module #	Description	Variable #	Description of Variables	Use
		Rehabilitative Employment			
		Related	1	actual relationship may be stated	
		Retirement Plan	1	list may be amended, added to or items deleted to reflect Policyholder's retirement plans	
		Sickness	1	may be deleted	
			2	may be deleted	
			3	may be Complications of Pregnancy	
			4	may be deleted	
		Substance Abuse	1	may be deleted	
		The Policy	1	Policyholder name and Policy number may be stated	
		Tips and Tokens	1	clause may be deleted or "monetary" may be deleted	
			2	may be "Your Employer"	
			3	clause and items 1 and 2 may be deleted	
			4	number will be 12 to 60 months or may be expressed in Calendar Years (1-5) or weeks (1-52)	
			5	may be actual date	
			6	may be specific period noted above	
		Total Disability or Totally Disabled	1	may be Complications of Pregnancy	
			2	may be deleted or percentage may be from 20-90%	
		Trust	1	trust may be named or described here	
		We, Our, or Us	1	National Guardian Life Insurance Company or National Guardian may be identified here	
		[Weekly] Benefit	1	may be "Monthly"	
			2	the entire phrase may or may not be included depending on case specifics	
			3	may be 9, 10, 11 or 12 months	
		Your Occupation	1	may be deleted; may be used with next paragraph; more specific description may be used	
			2	may be deleted; may be used with preceding paragraph; more specific description may be used	
		You or Your			
NHCRTSTD-E&E 4/08		Eligibility and Enrollment			
		Eligible Persons: *Who is Eligible for Coverage?*			Optional module if language is not in Policy of Incorporation
		Eligibility Waiting Period for Coverage: *When will I become Eligible?*	1	may be deleted if no waiting period for coverage	Optional module if language is not in Policy of Incorporation
		Enrollment: *How do I enroll for coverage?*	1	sentences may be deleted; references to Option 1 and Option 2 will reflect plans offered; Active Employees may be changed to reflect composition of the group and/or those eligible for which options offered	Optional module if language is not in Policy of Incorporation
			2	option(s) available may be stated here	

Page #	Module #	Description	Variable #	Description of Variables	Use
			3	may be deleted if no voice/electronic enrollment offered; specific instructions may be included here	
			4	entire section may be deleted or may be revised to accommodate Guaranteed Issue program	
			5	may be 31-60 days	
			6	reference to Annual Enrollment and/or Change in Family Status may be deleted or revised	
			7	Annual Enrollment may some other designation or time period	
			8	may be 31-60 days	
			9	may be deleted or Annual Enrollment may be referred to by some other designation	
		[Evidence of Insurability: *What is Evidence of Insurability?*	1	items in list may be added to or deleted; Written may include telephonic and/or electronic	Optional module if language is not in Policy of Incorporation
			2	may be "Our"	
		[Change in Family Status: *What constitutes a Change in Family Status?*	1	list may be added to or items may be deleted	Optional module if language is not in Policy of Incorporation
NHCRTSTD-PoC 4/08		Period of Coverage			
		Effective Date: *When does my coverage start?*	1	may be deleted or reference to "the Policy's costs" may be "the cost of coverage"	Optional module
			2	may be deleted	
			3	may be deleted	
			4	may be deleted or reference to "the Policy's costs" may be "the cost of coverage"	
			5	may be "the first day of the month following the date"	
			6	may be deleted	
			7	may be "the first day of the month following the date"	
			8	may be deleted	
			9	may be 31-60 days	
			10	may be "the first day of the month following the date"	
			11	may be deleted	
			12	may be deleted or may be some other reference	
			13	may be deleted	
		Deferred Effective Date: *Will coverage take effect if I am not Actively at Work on the date my coverage is to start?*	1	may be Complications of Pregnancy	Optional module
			2	may be deleted	
			3	may be deleted	
		Changes in Coverage: *Can I change my benefit options?*	1	either item may be deleted or a specific date maybe listed or may be at some other time or section may be deleted	Optional module
			2	may be 31-60 days	
			3	may be deleted	
			4	may be deleted or may reference options or dollar amounts specifically	

Page #	Module #	Description	Variable #	Description of Variables	Use
			5	section may be deleted	
			6	"the date" or "the first day of the month" may be some other time reference or item may be deleted	
			7	item 2 may be deleted	
			8	Change in Family Status section may be deleted	
			9	may be 31-60 days	
			10	item 2 may be deleted	
			11	may be deleted or either item deleted	
			12	may be deleted or class described	
			13	may be deleted or class described	
			14	may be deleted or either item deleted	
		Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*	1	section may be revised to require eligibility under the Prior Policy or some other criteria based on language of the Prior Policy; either item may be deleted or second item may be "receiving benefits under the Prior Policy"	Optional module
			2	entire section may be deleted if no pre-existing condition limitation under the policy	
			3	may be deleted	
			4	may be monthly or annually or quarterly	
			5	may be monthly or annually or quarterly	
			6	may be monthly or annually or quarterly	
			7	may be monthly or annually or quarterly	
			8	may be Part-time, temporary or other kind of employee	
			9	date may be specified	
			10	may be 1-12 months	
		Termination: *When will my coverage stop?*	1	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	Optional module
			2	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	
			3	item may be deleted	
			4	the date may be "the last day of the month following the month in which" or may be "the premium due date on or next following"	
			5	item may be deleted	
			6	may be "the date" or other period of time	
			7	list may be amended, added to or items deleted	
			8	may be deleted or "Part time" may be added or replace "Full time"	
			9	may be deleted	
		Continuation Provisions: *Can my insurance be continued?*		NOTE: the specific types of contiuation listed in this provision may be added to based on the Employer's plan of continuation specific to his or her particular business needs and requirements	Optional module
			1	may be deleted	
			2	reference to class and/or Participating Employer may be deleted	
			3	provision may be deleted	

Page #	Module #	Description	Variable #	Description of Variables	Use
			4	may be non-medical	
			5	may be "for [30] days after the date" where 30 may be 30-365 or may be expressed in months	
			6	provision may be deleted	
			7	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			8	provision may be deleted	
			9	may be 12-52 and/or second clause deleted	
			10	provision may be deleted	
			11	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			12	provision may be deleted	
			13	may be medical, non-medical or non-paid	
			14	may be "for [X] days after the date" where "X" days may be 30-365 or may be expressed in months	
			15	provision may be deleted	
			16	May be 8-52 weeks; or may be replaced by "8-52 weeks, or longer if required by other applicable law."	
			17	may be deleted	
		[Coverage while Disabled: Does my insurance continue while I am Disabled and no longer an Active Employee?	1	entire module may or may not be included	optional module
			2	references to "short term" may be changed to reflect benefits provided	
			3	may be deleted or "Part time" may be added or replace "Full time"	
		Period of Coverage-Continued			
		Extension of Benefits for Total Disability: *Do my benefits continue if the Policy terminates?*			Optional module
NHCRTSTD-BEN 4/08		Benefits			
		Disability Benefit: *What are my Disability Benefits under The Policy?*	1	may be deleted or either item deleted	
			2	may be "any Employer"	
			3	may be deleted or minimum shown here	
			4	may be 1/3, 1/4, 1/5 or 1/6	
		Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*	1	may be 3-90 days or 1/2 the number of Elimination days under LTD, if written together	
			2	may be "work"	

Page #	Module #	Description	Variable #	Description of Variables	Use
			3	may be 3-90 days or 1/2 the number of Elimination days under LTD, if written together	
		Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*	1	may be deleted	
		Termination of Payment: *When will my benefit payments end?*	1	item may be deleted	
			2	may be deleted	
			3	may be deleted	
			4	may be deleted	
			5	may be deleted	
			6	may be deleted	
			7	may be 60-100%	
			8	may be deleted	
			9	may be deleted	
			10	may be deleted	
			11	a) or b) may be included together or independently in this item	
			12	the phrase "or a Reasonable Alternative" may be deleted	
			13	may be deleted	
		Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*	1	provision may be replaced with one of the following 3 benefit options may be issued (F20, F21, F22)	
			2	may be deleted or "Benefits Commence" may be "Elimination Period"	
		Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*	1	percentage may be 20-80%	
			2	actual minimum may be shown	
			3	may be deleted or "Benefits Commence" may be "Elimination Period"	
		Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*	1	may be deleted	
			2	may be 80-100%	
			3	may be deleted or "Benefits Commence" may be "Elimination Period"	
NHCRTSTD-BEN-Rehab 4/08		Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*	1	may be deleted	
			2	may be 80-100%	
NHCRTSTD-BEN-Cola 4/08		Cost-Of-Living Adjustment: *How do my benefits keep abreast of inflation?*	1	may be "We may"	
			2	may be 12-36 months or expressed in years	

Page #	Module #	Description	Variable #	Description of Variables	Use
			3	item may be deleted	
			4	item may be deleted or % may be 20-50%	
			5	may be Policy Anniversary or some other date	
			6	may be 3-15%	
			7	may be 3/4 or deleted	
			8	may be deleted	
			9	may be 5 to unlimited	
			10	may name comparable CPI-W indicator or: "appproved by the Insurance Commissioner of the state in which the Policy is being delivered."	
NHCRTSTD-BEN-Caf 4/08		Cafeteria Plan Election Restriction			
NHCRTSTD-EXCL 4/08		Exclusions and Limitations			
		Exclusions: What Disabilities are not covered?	1	1 or more items in this list may be deleted	optional module
			2	phrase may be deleted	
			3	may be "accidental bodily injury" and "sickness" if LTD	
			4	may be "accidental bodily injury" and "sickness" if LTD	
			5	may be any or another	
		Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*	1	may be: We will pay benefits, or an increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition for a limited number of days as shown in the Schedule.	Optional module
			2	may be deleted	
			3	may be 90-365 days; 3-12 months	
			4	may be deleted	
			5	may be 90-365 days; 3-12 months	
			6	may be deleted	
			7	may be deleted	
			8	may be 30-180 days; 1-6 months	
NHCRTSTD-Prov 4/08		GENERAL PROVISIONS			
		Notice of Claim: *When should I notify the Company of a claim?*	1	may be deleted	Always included
			2	"written" may be deleted or may be "written, electronic or telephonic" or any variation thereof	
			3	may be 15-90 days	
			4	may be deleted	
			5	may be 15-90 days	
		Claim Forms: *Are special forms required to file a claim?*	1	may be deleted	Always included
			2	may be 15-45 days	

Page #	Module #	Description	Variable #	Description of Variables	Use
			3	may be 15-45 days	
			4	"written" may be deleted or may be "written, electronic or telephonic" or any variation thereof	
			5	may be deleted; 15 may be 15-45 days	
		Proof of Loss: *What is Proof of Loss?*	1	list may be added to or items may be deleted	Always included
		Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*			Optional module
		Sending Proof of Loss: *When must proof of Loss be given?*	1	may be 90-180 days	Always included
			2	may be 1-2 years	
			3	may be 30-90 days	
		Claim Payment: *When are benefit payments issued?*	1	may be "immediately"	Either H06 or H07 will be used
		Claims to be Paid: *To whom will my claim be paid?*	1	may be $1,000 - $7,000	Always included
		Claim Denial: *What notification will I receive if my claim is denied*			Always included
		Claim Appeal: *What recourse do I have if my claim is denied?*	1	may be 180-365 days	Always included
			2	may be 60-180 days	
		Social Security: *When must I apply for Social Security Benefits?*	1	may be 30-180 days	Optional module
		Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*			Optional module
		Overpayment: *When does an overpayment occur?*	1	items in list may be added to or deleted	Optional module
		Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*	1	may be 30-90 days	Optional module
			2	items in list may be added to or deleted	
			3	may be deleted	
		Subrogation: *What are the Company's subrogation rights?*	1	definition of "Third Party" may be included in next provision if this provision deleted.	Optional module
		Reimbursement: *What are the Company's Reimbursement Rights?*			Optional module
		Legal Actions: *When can legal action be taken?*	1	may be 60-180 days	Always included

Page #	Module #	Description	Variable #	Description of Variables	Use
			2	may be 3-6 years	
			3	may be deleted	
		Insurance Fraud: *How does the Company deal with fraud?*	1	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	Always included
			2	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	
			3	may be "Your Third Party Administrator" / "Policyholder" / "Association" / "Organization" or the like	
		Misstatements: *What happens if facts are misstated?*	1	may be deleted; or "except fradulent misstatements" may be added	Always included
		Policy Interpretation: *Who interprets Policy terms and conditions?*			Optional module
NHCRTSTD-RID 4/08		Rider Language	1	rider language may be attached to any benefit or provision herein in order to provide additional or optional benefits or provisions after the certificate is issued; may also be used to amend variable language in certificate after issue.	Optional module
			2	Policyholder name and Policy number may be stated	
			3	may be "certain" certificates	
			4	actual effective date may be stated here	
			5	may be deleted	
			6	signatures will change if officers change	

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association") may not provide coverage for the Policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Disability Insurance
Guaranty Association
c/o The Liquidation Division
1200 West Third Street (Third & Cross)
Little Rock, Arkansas 72201-1904

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Disability Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or disability insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE
However, persons holding such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation (“FPBC”) (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer’s obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE
The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Guaranty Association will not pay more than $100,000 in health insurance benefits, $100,000 in present value of annuity benefits, or $100,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.